AF REGULATION 160-13 AR 40-29 NAVMEDCOMINST 6120.2A CGCOMDTINST M6120.8B 20 October 1989

Medical Service

MEDICAL EXAMINATION OF APPLICANTS FOR UNITED STATES SERVICE ACADEMIES, RESERVE OFFICER TRAINING CORPS (ROTC) SCHOLARSHIP PROGRAMS, INCLUDING 2- AND 3-YEAR COLLEGE SCHOLARSHIP PROGRAMS (CSP), AND THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES (USUHS)

This regulation gives a uniform procedure for carrying out medical examinations of applicants for US service academies, Reserve Officer Training Corps (ROTC) Scholarship Programs and the Uniformed Services University of the Health Sciences (USUHS). It applies to all medical facility personnel who perform such medical examinations, including the Air National Guard and US Air Force Reserve Units.

This regulation is affected by the Privacy Act of 1974. Each form required by this regulation and which involves the Privacy Act either contains a Privacy Act Statement incorporated in the body of the document or is covered by DD Form 2005, Privacy Act Statement—Health Care Records. For a list of abbreviations shown in this publication, see attachment 1.

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1. General Provisions:

a. DD Forms 2351, DOD Medical Examination Review Board (DODMERB) Report of

Medical Examination, and 2492, DOD Medical Examination Review Board (DODMERB) Report of Medical History, will be used to record

medical examination results for the DODMERB only. They will not be used to record the results of medical examinations for any other Department of Defense (DoD) medical examination.

- b. Every authorized applicant for a United States service academy (Military, Naval, Air Force, Coast Guard, Merchant Marine), ROTC Scholarship Program, or the USUHS, must take a complete medical examination as described in this regulation. Physicians or dentists must not terminate the examination if they note presumably disqualifying defects.
- c. An examinee's medical status is determined by the DODMERB. Examining physicians must not recommend waivers. They must not discuss with examinees how their medical findings affect examinee medical qualifications.
- d. When the examinee wishes to present certificates from private physicians, or other forms of medical documentation, these documents must be sent to the address shown in paragraph 5c, with the completed examination. If an examinee wishes to submit evidence to rebut a medical disqualification by the DODMERB, the examinee must be advised to submit the material directly to the address in paragraph 5c. Such material should not be submitted to the examining physician, since that physician has no power to take further action.
- e. The medical or dental examiner may, in the course of the medical examination or subsequent to it, discuss the findings of the examination with the examinee, parents, or guardians. The discussion must be limited to the medical significance of those findings, and recommendations must be related only to the examinee's health and well-being. The examiner must not relate the significance of any findings to the examinee's medical qualifications or disqualification for a service academy or ROTC scholarship program.
- f. The medical or dental examiner must tell the examinee to seek further medical or dental care for any findings that may affect the examinee's health and well-being. As an example, if the blood pressure is elevated, the examinee must be told to see his or her own physician for further evaluation.
- 2. Authorized Applicants. Medical examinations are conducted for only those applicants the DODMERB has officially scheduled (Medical Treatment Facility (MTF) will have been officially notified of applicants who have been scheduled at their facility). If unscheduled applicants call or appear in person and request a

medical éxamination, the medical facility will refer them to the DODMERB. The DODMERB notifies applicants of the date and times their examinations have been scheduled.

- 3. Where Examinations Will Be Performed. Applicants may take qualifying examinations only at those facilities the DODMERB designates.
- 4. Scheduling Notification to Examining Facilities. The DODMERB sends each examining facility a list of applicants scheduled for examination, about 15 days before the examination date. On the examination day, each examining facility will mark a copy of the list to identify any applicants who did not report for examination, and return it to the DODMERB immediately.

5. Completion and Disposition of Forms:

- a. The examining dentist completes DD Form 2480, DOD Medical Examination Review Board (DODMERB) Report of Dental Examination, according to paragraph 9a, and signs it. The examining physician completes DD Form 2351 (attachment 2), and DD Form 2492 (attachment 3) according to paragraph 9b. The examining physician must sign and date the original DD Forms 2351 and 2492. Also, the medical officer responsible for the examination's accuracy and completeness must sign item 59 on the original DD Form 2351.
- b. Within 10 workdays after the examination, the examining facility must send the following to the address in c below:
- (1) The original DD Form 2351, properly signed and authenticated (see a above).
 - (2) Any consultation reports.
- (3) Laboratory reports (if any, other than those recorded on DD Form 2351, items 27, 28, and 29).
- (4) The DD Form 2492, signed by the examinee and the examining physician.
- (5) The SF 520, Clinical Record—Electrocardiographic Record, showing electrocardiographic (ECG) tracings, properly mounted, identified, and interpreted. (Multiple channel ECGs need not be mounted).
- (6) DD Form 2480, properly annotated and signed by the examining dentist (attachment 4).
- (7) All dental radiographs (bite-wings and panoramic x-rays) properly processed.
- (8) All medical documentation the examinee presented.

- (9) Diagnostic dental casts, if required by paragraph 9a(4), sent in a separate package, marked with the examinee's name and social security number (SSN).
- c. All items required by b above must be sent to the DODMERB. Assemble and staple all forms and dental radiographs in the order listed. Address material to: DOD Medical Examination Review Board (DODMERB), USAF Academy CO 80840-6518. DO NOT address mail to Commanding Officer, USAF Academy CO 80840-6518. This results in medical correspondence being routed to the Superintendent's office at the Air Force Academy, where it will be delayed in reaching the DODMERB.
- d. The examining facility must keep one complete copy (carbon or duplicate) of each item in b above, except b(8), then dispose of these items according to parent service record disposition standards; e.g., AFR 12-50, volume II.
 - e. Some helpful hints:
 - (1) Do:
- (a) Mail as many examination reports in one package as possible.
- (b) Send packages weighing 12 ounces or less as First-Class Mail.
- (c) Send packages weighing over 12 ounces as "Priority" mail.
- (d) Staple all papers and x-rays in the upper left corner.
- (e) Review all items for legibility and positive identification of the examinee.
 - (2) Do Not:
 - (a) Send a letter of transmittal.
- (b) Complete or send any Privacy Act Statement (DD Form 2005, Privacy Act Statement—Health Care Records).
- (c) Send medical examination reports or remedial medical information via Certified or Registered mail.
- 6. Hospitalization of an Applicant. When hospitalization is required as part of the medical examination, the applicant may be admitted to a DOD MTF under the authority of appropriate service regulations; e.g., AFR 168-6, AR 40-3, NAVMEDCOMINST 6320.3, Uniform Military Training and Service Act (62 Stat 604.50 U.S.C., App 451).
- 7. Civilian Consultation and Additional Evaluations. When supplemental reports, such as specialty consultations and laboratory procedures,

- are essential to evaluate an examinee properly, the examining facility should do them whenever possible.
- a. If these services are not available, the facility may purchase these services from civilian sources, at government expense, providing funds are available. If funds are not available, or these service cannot be offered because of scheduling, distance, or the like, the examinee must be given the opportunity to travel at his or her own expense to a government facility that can provide these services. In that case, tell the examinee to call the other government facility for an appointment in advance. The examinee may also get these services, at his or her own expense, from a civilian source, and have results sent directly to the address in paragraph 5c. Applicant should be provided SF 513, Medical Record—Consultation Sheet, which provides pertinent history and specifically delineates the specialty information needed and authorized lab tests required. Invasive or potentially dangerous procedures are not authorized. Communicate with DODMERB in questionable cases.
- b. Results of the medical examination should be sent without waiting for supplementary evaluations or their results. Any instructions given to the examinee will be explained on DD Form 2351. Results of additional tests or evaluations should be sent separately, when they become available.
- 8. Direct Communication. The Director, DOD-MERB, is authorized to communicate directly with the commanders of each designated examining facility about medical examinations, procedures, techniques, deficiencies, and general supervision of medical examination processing. The Director, DODMERB, may send a copy of any correspondence with the examining facilities to the office of primary responsibility of the appropriate Surgeon General office.

9. Scope of Examination:

a. Dental Examination:

(1) General Information. The dental officer thoroughly examines the mouth, teeth, and supporting structures of the examinee and records his or her findings in blue-black or black ink on the DD Form 2480 (attachment 4). While the examining dental officer must inform the candidate of existing deficiencies, pathology, or abnormalities, the examiner is not authorized to advise the examiner whether or not he or she is within dental standards. Therefore, the dental

examiner should not point out the specific treatment that might be needed to meet the standards. If such instructions are necessary, the DODMERB must give these instructions to the examinee after evaluating all results of the dental examination. Generally, all dental expenses will be borne by the examinee. Dental radiographs and study casts are authorized to be obtained from the Departments of the Army, Navy and Air Force dental facilities at no expense to the examinee.

- (2) Dental Radiographs. All examinees receive the Type 2 Dental Examination. This includes both mirror and explorer examination under adequate illumination. Bite-wing radiographs on bite-wing film and a panoramic radiograph are required. When an examinee is wearing a fixed, active orthodontic appliance, excluding retainers on both arches, only a panoramic radiograph is required. Bite-wing x-rays are not needed in these cases. A full mouth x-ray survey should not be performed in place of a panoramic x-ray.
- (a) If the examination facility does not have a panoramic x-ray, offer the examinee the opportunity to go to another government facility, traveling at his or her own expense. In such cases, advise the examinee to call for an appointment. As an alternative, the examinee may obtain the panoramic x-ray (and not a full-mouth survey) from a civilian dentist at his or her own expense.
- (b) The examining dental officer may obtain additional radiographs (for example, periapical or occlusal views) if it is necessary to demonstrate pathology or other abnormalities.
- (c) Identify all radiographs with the examinee's full name and SSN. Process thoroughly, and wash and dry radiographs before sending them to the DODMERB. All x-rays must be of diagnostic quality.
- (3) Charting Dental Defects. All dental defects of the examinee are shown on DD Form 2480. Indicate on the chart (DD Form 2480, item 3) all teeth that are restorable or nonrestorable, missing teeth, teeth replaced, spaces closed, location of cavities, and any defects or abnormalities of the teeth and surrounding structures. Do not chart existing restorations unless they are defective.
- (4) Diagnostic Dental Casts. In cases of questionable occlusion, disfiguring spaces between anterior teeth, malformation of the jaw, or malrelation of the jaw, dental casts must be made of maxillary and mandibular dental

- arches. Leave any existing prosthetic appliances in place when you make impressions. Draw pencil lines across facial surfaces of both casts to show the habitual occlusal relationship. Identify each cast clearly with the examinee's name and SSN, and send both casts to the DOD-MERB. Indicate on DD Form 2480, item 10l, that you are sending casts.
- (5) Malocclusion. Any questionable occlusion or definite malocclusion related to an insufficient incisal or masticatory function, the malformation or malrelation of jaws or opposing teeth, or a facial deformity must be noted on the DD Form 2480, item 10. Any additional remarks about the type, degree, or severity of the malocclusion should be added in item 16 (attachment 4).
- (6) Orthodontics. If the examinee wears a fixed, active orthodontic appliance, or is undergoing orthodontic treatment that includes an active removable appliance, or is wearing retainer appliances, or has a past history of orthodontic treatment, please note that fact on the DD Form 2480, item 11.
- (7) Periodontal Conditions. If significant periodontal disease is present (not simply gingivitis), the location, nature, and severity of the problem must be described on the DD Form 2480, item 13.
- (8) Dental Prostheses. The dental examination must include an opinion about the service-ability of all dental prostheses. A serviceable prosthesis must adequately restore masticatory function and appearance, and permit clear speech. Oral tissues supporting the prosthesis must be healthy. Any comments must be recorded on the DD Form 2480, item 12.
- (9) Cleft Palate or Cleft Lip. If the examinee has a history of cleft palate or cleft lip, whether repaired or not, your comments must be recorded on the DD Form 2480, item 9d and e, to include existing fistulae or other defects.

b. Medical Examinations:

- (1) DD Form 2492, DODMERB Report of Medical History:
- (a) The examinee's complete medical history must be recorded on the DD Form 2492.
- (b) The examinee completes the first two lines, all of Sections I and II (items 1 through 94), and the Remarks (if necessary) of the DD Form 2492 in his or her own handwriting, using blue-black or black ink or indelible pencil.
- (c) The examinee's identification is selfexplanatory, but you may help the examinee fill out these items in the standard format.

- (d) The examinee completes items 1 through 94 and Remarks (the examinee should mark "Not Applicable" or "N/A" in item 9, if appropriate). If item 21 "wear contact lenses or ocular eye retainers," is marked "yes," explain type of lenses or retainers and length of time removed before examination (see attachment 3). As the examinee may give vague or imprecise information in the "Remarks" section, all answers must be carefully reviewed, and the examinee asked to clarify answers, whenever necessary (note that answers in items 1 through 10 do not need remarks). The examiner must elaborate on medical history items that are not adequately explained by examinee.
- (e) Some general guides for completing examiner's summary and elaboration of pertinent data:
- 1. Do not use the term "usual child-hood illnesses." You may group childhood illnesses together, listing each one.
 - 2. Record the date or age of incidents.
- 3. Do not use "NS" or "nonsymptomatic" in the history. You may use "NCNS," "no comp, no seq," or "no complications, no sequelae" after items of history.
- 4. Elaborate on all items of history answered "Yes" that are not adequately explained by examinee. Number your amplifying responses to correspond to the affirmative responses on DD Form 2492.
- (2) DD Form 2351. Attachment 2 gives an item-by-item explanation of DD Form 2351, with model entries. Complete all items, as specified.

10. Supply of Forms:

- a. DD Forms 2351, 2480, and 2492 are part of the scheduling package DODMERB sends to lists of applicants provided by the academies, ROTC programs and the USUHS.
- b. Local reproduction of blank DD Forms 2351, 2480, and 2492 is authorized by the Army, Navy, Coast Guard, and Air Force through the applicable forms manager and reproduction facility. Print DD Forms 2480 and 2492 head-to-foot. Print DD Form 2351 face only.
- c. The DD Forms listed below are provided to the applicant by DODMERB when remedial medical tests are required; however, a small stock of these forms will be maintained by each medical facility in the event applicants arrive at the medical facility without the appropriate forms to record remedial test results. Local

- reproduction is authorized based on the specific requirement of the particular agency.
- (1) DD Form 2369, DOD Medical Examination Review Board (DODMERB) Cycloplegic Refraction (attachment 5).
- (2) DD Form 2370, DOD Medical Examination Review Board (DODMERB) Three-Day Blood Pressure and Pulse Check (attachment 6).
- (3) DD Form 2371, DOD Medical Examination Review Board (DODMERB) Update of Applicant's Medical Examination (attachment 7).
- (4) DD Form 2372, DOD Medical Examination Review Board (DODMERB) Statement of Present Health (attachment 8).
- (5) DD Form 2374, DOD Medical Examination Review Board (DODMERB) Heart Murmur Evaluation (attachment 9).
- (6) DD Form 2375, DOD Medical Examination Review Board (DODMERB) Pulmonary Function Studies (attachment 10).
- (7) DD Form 2377, DOD Medical Examination Review Board (DODMERB) Red/Green Color Vision Test (attachment 11).
- (8) DD Form 2378, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Headaches (attachment 12).
- (9) DD Form 2379, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Head Injury (attachment 13).
- (10) DD Form 2380, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Sleepwalking (attachment 14).
- (11) DD Form 2381, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Motion Sickness (attachment 15).
- (12) DD Form 2382, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Hay Fever, Sinusitis, Asthma and/or Allergies (attachment 16).
- (13) DD Form 2383, DOD Medical Examination Review Board (DODMERB) Statement of Use Regarding Medication (attachment 17).
- (14) DD Form 2489, DOD Medical Examination Review Board (DODMERB) Farnsworth Lantern Color Vision Test (attachment 18). When locally reproduced, print head-to-foot.
- d. DD Forms 2368, DOD Medical Examination Review Board (DODMERB) Service Academy ROTC Medical Qualification Determination; 2373, DOD Medical Examination Review Board (DODMERB) Notification of Failure to Appear for Service Academy ROTC Medical

Examination; and 2503, DOD Medical Examination Review Board (DODMERB) Applicant Overseas Appointment, are stocked and used only by DODMERB.

e. Attachment 19 provides guidelines for conducting certain medical tests; e.g., Reading Aloud Test (RAT), sitting height, Red Lens Test, etc.

BY ORDER OF THE SECRETARIES OF THE AIR FORCE, THE ARMY, THE NAVY, AND THE DEPARTMENT OF TRANSPORTATION

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US Coast Guard

SUMMARY OF CHANGES

This revision clarifies procedures MTFs will follow when applicants arrive who are not scheduled by DODMERB (para 2); permits the use of DD Form 2492 as an exception to SF 93, Report of Medical History, which will be used to report a medical history to DODMERB (paras 5a and 9b); advises examining facilities of the proper format for addressing medical correspondence to the DODMERB (para 5c); includes remedial medical information as being prohibited from being mailed Certified or Registered Mail (para 5e(2)(c); clarifies procedures examining physicians will follow when applicant must be hospitalized as part of the medical examination (para 6); adds additional information about applicants requiring specialty consultations and laboratory procedures before their examination (para 7); redesignates DODMERB Form 6, Report of Dental Examination to DD Form 2480 (para 9a); adds a list of abbreviations (atch 1); adds an explanation and model entry for blood alcohol testing and urine drug screen (atch 2, item 29); rescinds DD Form 2376, Supplemental Statement of Medical History.

Distribution:

Air Force: F

Army: Active Army, ARNG, USAR: To be distributed in accordance with the requirements on DA Form 12-09-E, block number 3434, intended for command level B.

Navy: Ships and Stations Having Medical Department Personnel.

(Stocked: CO, NAVPUBFORMCEN, 5801 Tabor Ave., Phila., PA 19120-5099)

Coast Guard: To be distributed by Commandant (G-TIS) pursuant to COMDTNOTE 5600

LIST OF ABBREVIATIONS

ANSI-American National Standards Institute

ASA-American Standards Association

BAT-Blood Alcohol Test

cm—Centimeters

CSP-College Scholarship Program

CT-Cover Test

°-Degree

DOD-Department of Defense

DODMERB—Department of Defense, Medical

Examination Review Board

DPA-V-Depth Perception Apparatus-Ver-

hoeff

ECG-Electrocardiographic

EKG-Electrocardiogram

FALANT-Farnsworth Lantern

GU-Genitourinary System

HIV—Human Immune Virus

Hz-Hertz

ISO—International Standards Organization

mm-Millimeters

MTF-Medical Treatment Facility

NCNS-No Complications, No Sequelae

NE-Not Examined

NPC-Near Point of Convergence

NS—Nonsymptomatic

OTC—Over the Counter

PA-Physician Assistant

PAS—Privacy Act Statement

PC-Point of Convergence

PCNP—Primary Care Nurse Practitioner

POC-Professional Officer Course

RAT-Reading Aloud Test

RBC-Red Blood Cell

ROTC—Reserve Officer Training Corps

SSN-Social Security Number

UDS-Urine Drug Screen

USUHS-Uniformed Services University of the

Health Sciences

VTA-ND-Vision Test Apparatus-Near and

Distant

VTS-CV-Vision Test Set-Color Vision

WBC-White Blood Cell

WHNS-Well Healed, No Sequelae

DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION

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ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351

Explanation	Model Entry
Item 1—Date of Examination. Record dates in military style.	14 January 1985 21 Mar 85
Item 2—Last Name, First Name, Middle Name. Record the entire middle name.	Jones, Harry William, Jr. Martinez, Catherine, Lucinda
Item 3—Social Security Number.	111-22-3333 001-01-1001
Item 4a—Date of Birth. Record date in military style.	15 Feb 68 29 Apr 67
Item 4b—Age.	17 18
Item 5—Sex. Do not abbreviate.	Male Female
Item 6—Race (Ethnic Group). Do not abbreviate. Do not confuse with religion.	Caucasian, Black, Oriental, Indian (American), Puerto Rican, Mexican-American
Item 7—Home Address. Enter the address and nine-digit ZIP code where the examinee receives mail.	1234 Main St. Colorado Springs CO 80840-6518
Item 8—Military Status. Check the block designating the applicant's current status.	
Item 9—Examiner Address. Complete name and address of agency doing examination	USAF School of Aerospace Medicine Brooks AFB TX 78235-5000
Item 10—Height. Record standing height in inches, without shoes, to the nearest quarter of an inch. Also measure every applicant's sitting height to the nearest quarter of an inch, and record it.	Standing 61 1/4 Sitting 36 3/4
Item 11—Blood Pressure. Record the sitting blood pressure.	120/84
Item 12—Electrocardiogram (EKG). Give every examinee a 12-lead EKG. The examinee does not have to be fasting. Check normal or abnormal, and submit actual tracings.	
Item 13—Audiometer. Give an audiometer test, include frequencies 500, 1000, 2000, 3000, 4000, and 6000 Hertz (Hz). Indicate the type of standard (American National Standards Institute (ANSI) American Standards Association (ASA), 1951, or International Standards Organization (ISO), 1964.	
Item 14—Reading Aloud Test (RAT). Give the RAT (attachment 19) and mark it as "satisfactory" or "unsatisfactory." If RAT is unsatisfactory, summarize the defects that caused failure in item 57.	
Item 15—Pulse. Record the resting pulse in beats per minute.	72
Item 16—Weight. Measure weight in pounds, to the nearest whole pound, with the examinee wearing no more than underwear.	150

Items 17 through 26. Before conducting vision test, find out if the examinee is wearing contact lenses. Soft contact lenses must be removed a minimum of 3 days before the examination. All other types of contact lenses (hard, semisoft, retainers, color-correcting, etc.) must be removed 21 days before the examination. If contact lenses have not been out the required period of time, note the fact in item 57 and continue with the examination. Have the examinee remove them for those tests where lenses would obviously cause erroneous results, such as items 17 and 19 (uncorrected vision). If the examinee usually wears corrective lenses (spectacles or contacts), have the examinee wear them during depth perception and color vision testing; however, make sure that lenses are not "color corrective."

Item 17—Distant Vision. Record distant visual acuity with a constant numerator of 20 (20 feet), and a denominator that depends on the individual's vision. If acuity is worse than 20/20, right eye or left eye, then record the correctable visual acuity. If the examinee is not able to read all of the letters on the 20/20 line, then record the number of missed letters; e.g., 20/20-1; 20/30-2; 20/20-3, etc., or record the next higher line; e.g., 20/20-3 = 20/25. Measure visual acuity with Vision Test Apparatus-Near and Distant (VTA-ND), or in the eye lane. When using the VTA-ND and the examinee does not successfully complete the top line of the 20/400 line, then record 20/400+ or refer examinee to the optometrist to determine the proper visual acuity.

Item 18—Refraction. OTHER THAN US AIR FORCE ACADEMY. Complete this item on every examination where distant or near visual acuity is worse than 20/20, right eye or left eye. Enter the prescription that corrects acuity to 20/20, and after the word "Refraction" mark how you derived that prescription; "manifest," "cycloplegic," or "lens" if the prescription is read from spectacles.

US AIR FORCE ACADEMY. Every applicant for the US Air Force Academy whose uncorrected distant visual acuity is 20/20 or better in both the right and left eyes must have a cycloplegic refraction. Enter the prescription that corrects acuity to no better than 20/20 and after the word "Refraction" check "CYCLO."

Item 19—Near Vision. Record results in terms of reduced Snellen. Whenever the uncorrected vision is worse than normal (20/20), show the corrected vision for each eye, and lens value after the word "by."

Item 20—Heterophoria. In routine testing for heterophoria, check only "Far" on the VTA-ND, or "20" in the eye lane. Do not enter the symbol for diopters; the unit of measurement is understood. Enter the amount of exophoria or esophoria and right or left hyperphoria.

Model Entry

20/50 corrected to 20/20 20/20-3 corrected to 20/20 20/400+

Refraction (manifest By SPH -1.50 CYL +.50 AXIS 090

20/40 corrected to 20/20 by same. 20/40 corrected to 20/20 by +0.50

Es° Ex° R.H. L.H. 8 0 1 0

Item 21—Cover Test. Test muscle balance deviation (phorias or tropias) by use of the objective Cover Test (CT). If you find esotropia or exotropia on the CT (cross or alternate cover and cover-uncover) check "fail" and record the amount in the bottom of the box. If the examinee is orthophoric, check "pass."

Item 22—Color Vision. Test examinees with the standard 15-plate Vision Test Set, Color Vision (VTS-CV). Check the test(s) used and enter both the number passed and the number failed. If the Farnsworth Lantern (FALANT) is available, use it for those who fail the plate test. Also, use it if you suspect the examinee has memorized the plates. Enter FALANT results to the right of the word "FALANT." Be sure to specify the name of other tests and the numerical result. If the examinee fails the FALANT or 15-plate Vision Test Set, check for the ability to distinguish and identify, without confusion, those colors of objects, substances, materials, or lights that are vivid red and vivid green; record results in item 57.

Item 23—Depth Perception. Test the examinee with correction, if any. For VTA-ND if the examinee passes, enter "passes" and give the highest level passed (D, E, or F) in parentheses. For Verhoeff (DPA-V), enter "passes" or "fails" and the number correct over number presented. For Titmus/Stereo Fly, circle the actual test used and enter the numerical result.

Item 24—PC (Near Point of Convergence). Measure the near point of convergence (NPC) in millimeters (mm).

Item 25—Accommodation. Have the examinee take this test with corrective lenses if worn.

Item 26—Red Lens Test. Note the point on the screen where diplopia or suppression develops. Mark "pass" if the examinee has no diplopia or suppression within 20 inches of the primary position in the center of screen, with the examinee seated 30 inches from the screen. Describe any abnormalities accurately in item 57.

Item 27—Urinalysis. Check the appropriate boxes for protein and sugar. Indicate results of microscopic examination; multi-reagent strips may be used if negative. If the multireagent strip is not negative, an actual microscopic examination must be performed and the results annotated.

Item 28a and b—Blood Type and RH Factor. Record results in these blocks.

Item 28c and d—Hematocrit and Hemoglobin. A hematocrit or hemoglobin level is required.

Item 29—Other Tests. For other medical tests as indicated; e.g., HIV (all exams), dental results (POC only), blood alcohol testing (BAT) and urine drug screen (UDS).

Model Entry

- a. VTA-ND passes (F)
- b. DPA-V *passes* (8/8)
- c. Titmus/Stereo Fly 70

35mm

Right 10.0, Left 9.5

Diplopia in left lateral gaze, 10 inches from primary position.

2 RBC 3 WBC

Type A
Rh factor—Pos

Hematocrit 44 Hemoglobin 16.5

HIV—Negative Dental Class 2 BAT—Negative UDS—Collected

Items 30 through 56—Clinical Evaluation. Make a check in the proper column. When there are clinical findings to record or comment on, check the proper column (normal or abnormal) and enter pertinent information in the space provided to the right, beginning with the item number. (See instructions on DD Form 2351).

Item 30—Head, Neck, Face, and Scalp. Record all swollen glands, deformities, or imperfections of the head and face. If enlarged lymph nodes of the neck are detected, describe them in detail and give a clinical opinion of the etiology.

Item 31—Nose. Record all abnormal findings. If septum is deviated, estimate the degree of obstruction and tell whether airflow is adequate.

Item 32—Sinuses. Record objective findings only.

Item 33—Mouth and Throat. Note whether tonsils have been removed. Record any unusual findings.

Item 34—Ears—General (Including External Canals). If operative scars are noted over the mastoid area, include a notation of simple or radical mastoidectomy in item 57.

Item 35—Drums (Perforation). Record the location and size of any perforation. If there is scarring of the tympanic membrane, record the percent of the membrane involved, and evaluate the mobility of the membrane.

Item 36—Valsalva. Indicate whether or not both eardrums move on Valsalva Maneuver (mark normal only if both drums move).

Item 37—Eyes—General. When there is ptosis of lids, make a statement about the cause and whether it interferes with vision. When you detect a pterygium, note the following:

- (a) Encroachment on the cornea.
- (b) Progression.
- (c) Vascularity. Check particularly for radial keratotomy or evidence of orthokeratology or other procedures employed to improve visual acuity.

Item 38-Pupils (Equality and Reaction).

Item 39—Ocular Motility (Associated Parallel Movements, Nystagmus).

Item 40—Ophthalmoscopic. If you detect opacities of the lens, make a statement about size, type, progression, and interference with vision.

Model Entry

- a. 2cm vertical scar right forehead, well healed, no sequelae (WHNS).
- b. 2 discrete, freely movable, firm, 2cm nodes in right anterior cervical chain, probably benign. Has upper respiratory infection.
- a. Moderate obstruction on right, due to septal deviation, airflow adequate, asymptomatic.
- b. Mouth breathing noted.
- c. Large nasal polyps present in both chambers.

Marked tenderness over left maxillary sinus. Poor transillumination.

Tonsils enucleated.

Bilateral severe swelling, injection, and tenderness of ear canals.

Small perforation, right upper quadrant of left tympanum.

No motion on valsalva, right ear.

- a. Ptosis, bilateral, congenital. Does not interfere with vision.
- b. Pterygium, left eye. Does not encroach on cornea, nonprogressive avascular.

Redistribution of pigment, macula, right eye, possibly due to solar burn. No evidence of active organic disease.

Item 41—Lungs and Chest (Include Breasts). Record all abnormal findings. Note whether there are any abnormalities of the rib cage, muscles, chest excursion, palpation, percussion, and auscultation.

Item 42—Heart (Thrust, Size, Rhythm, Sounds). Describe any abnormal heart findings completely. Whenever you hear a cardiac murmur, describe the time in the cardiac cycle, and the intensity, location, transmission, and effect of respiration or change in position; and state whether you think that the murmur is organic or functional. When describing murmurs by grade, indicate basis of grade (IV or VI). Note any additional sounds (clicks, etc.) and their time in the cardiac cycle, synchrony, and intensity; and whether you think they are of cardiac origin or adventitious.

Item 43—Vascular System (Varicosities, etc.). Describe any abnormalities adequately. When varicose veins are present, give their location, severity, and evidence of venous insufficiency. Check for the presence or absence of carotid, radial, femoral, popliteal, and pedal pulses. Specifically, record any absent pulses or presence of a bruit over any artery.

Item 44—Abdomen and Viscera (Include Hernia). Note any abdominal scars and describe the length in centimeters, their location and direction. If you find a dilated inguinal ring, state whether a hernia is present or absent.

Item 45—Endocrine System. Specifically record asymmetry, enlargement, or the presence of nodules in the thyroid gland.

Item 46—Spine, Other Musculoskeletal (Including Pelvis, Sacroiliac, and Lumbosacral Joints). If you detect scoliosis or other musculoskeletal defects, either by examination or as an incidental chest x-ray finding, describe any defects as accurately as possible.

Item 47—Upper Extremities. Record any deformity or limitation of motion. If the applicant has a history of previous injuries or fracture of an upper extremity (for example, a history of a broken arm with no significant finding at time of examination), indicate that there is no deformity and function is normal. Make a positive statement, even though you check the "Normal" column.

Item 48—Lower Extremities. Report as in item 47.

Item 49—Feet. Note any abnormality. When you detect flat feet, make a statement about the stability and the presence or absence of symptoms. Do not express pes planus in degrees; record it as mild, moderate, or severe. Indicate if orthotic devices or special footwear are used.

Item 50—Identifying Body Marks, Scars, or Tattoos. Record only scars or marks useful for identification.

Model Entry

Sibilant and sonorus rales throughout chest.

Prolonged expiration.

a. Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. disappears on exercise and deep inspiration (physiologic murmur)

b. Late soft systolic "click" heard over the second left intercostal space, parasternally, not varying in intensity with respiration, probably of cardiac origin.

Varicose veins, mild posterior superficial veins of legs. No evidence of venous insufficiency. Asymptomatic.

2.5cm linear diagonal scar right lower quadrant, well healed, no sequelae (WHNS).

Left lobe diffusely enlarged; 2cm hard, nontender nodule near isthmus.

Scoliosis, thoracic spine, minimal deviation to right.

No weakness, deformity or limitation of motion, left arm.

Flat feet, moderate, stable, asymptomatic.

a. 1cm vertical linear scar, dorsum left forearm, WHNS.

b. 3cm heart-shaped tattoo, lateral aspect, middle 1/3 left forearm.

Item 51—Skin, Lymphatics. Describe pilonidal cyst or sinus, and tell whether symptomatic in past or at present. If there is a skin disease, tell what it is, record its chronicity, severity, and response to treatment in item 57. If you detect a skin disease of the face, back, or shoulders, state whether the defect will interfere with wearing an oxygen mask or whether wearing a parachute harness, shoulder straps, or other military equipment will irritate it.

Item 52—GU (Genitourinary) System. If you detect a varicocele or hydrocele, indicate the size in relation to the opposite testicle and whether it is symptomatic. If you detect an undescended testicle, describe its location, particularly in relation to the inguinal canal.

Item 53—Anus and Rectum. Check for hemorrhoids, and note size, number, and symptomatology. Check for fistula, cysts, etc. At least a visual examination is required on all examinees.

Item 54—Pelvic Examination. Perform a pelvic examination only if medically indicated. If the examination is not performed, enter "NE" in the Normal column. This examination is required for all female examinees 22 years of age and over.

Item 55—Neurologic. Record complete description of any abnormality.

Item 56—Psychiatric. Interview each applicant to evaluate level of maturity, and ability to withstand the rigorous physical and mental stresses of military service. Explain any negative recommendations in detail.

Item 57—Notes. Use this space to describe conditions found during the Clinical Evaluation (items 30 through 56). This space should be used for any other comments relating to items 10 through 29. Be sure to enter the item number before each comment. Use the back of the form, if necessary.

Item 58a—Typed or Printed Name of Examiner. The examiner identified must sign the original. Use block for Physician Assistant (PA) or Primary Care Nurse Practitioners (PCNP) who perform clinical aspect of examination.

Item 58b-Signature of Examiner.

Item 58c-Rank.

Item 58d-Corps or Degree.

Item 59a-Typed or Printed Name of Physician.

Item 59b-Rank.

Item 59c-Degree.

Model Entry

- a. Acne vulgaris, mild, face, will not interfere with wearing oxygen mask or combat equipment.
- b. 5×5 cm burn scar, left pretibial region. May be subject to trauma by combat boots, or breakdown by water immersion.

Varicocele, left, small, asymptomatic

One small external hemorrhoid, asymptomatic.

DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY—MALE

are a second of the office of medic	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.) (This form is subject to the Privacy Act of 1974 See DD Form 2005) Expires Sep 30, 1989															
NAME (Last, First, Middle Initial)	ect to	5 (1)					OCIAL SECURITY	NUF	AB E	R			NE NO. (include are	a code)		٦
MORAY, HARRY G.						(011-11-000	1			(102)	962-0001			╝
PURPOSE OF EXAMINATION DODMERB EXAMINA USAF C	rior lir	N F	ACILITY OR EXAMI Hanscom, Ha	NEF ans	R A	N DE	m Fld MA 0	lude Zi 110	o co l	dej			DATE OF EXAM 5 May 87	INATIC)N	
SECTION I - Mark applicable boxes in ite	ns 1	th	rough 10													_
1. How would you rate your present healt					_	-	. If you smoke ci	_	_	ho		_			_	4
X Excellent Very Good Good		F	air Poor		1	Ċ	Less than 1 pack	ام ۱	CK		1 1/2 packs		2 packs or more			_
2. How many hours sleep do you usually o	et a	t n	ight?		Ţ	7.	On the average	e, ho	w m	an	y times per wee	k d	o you drink any	alcohol	lic	
4 or less 5 6 7 X 8	Γ		or more		l	_	beverages suci							1.		4
3. How many days per week do you exerc	ise	vig	orously		12	X	(skip to item 9)	_	tha e		Once or twice	Ц	Three or four	more	_	4
(enough to produce a sweat) for at least fiftee	T	l s			4	8.	. When you drin	k, ho	wr	nar	ny alcoholic drin	KS C	lo you have (on th	e averag		\vdash
None 1 2 3 X 4	ட	١,	6 7		+,	_	. Have you ever	V.	20	v ~	f the following?	H	1/A	1-4-		٦
4. Are you on any special diet?					+	J .	Amphetamines		bitur			ΓÌ	Chemical inhalants			\dashv
Yes X No					+		Cocaine		lucin			Н	Narcotic drugs			\dashv
5. Indicate the tobacco products you curre	ntly	T	Chewing tobacco		+,). What is your m		_	÷						ᅥ
X Cigarettes Cigars	_	╀	None (Skip to item 7)		+	X	Never Married		rried		Separated		Divorced	Wide	owe	J
Shuff (Smokeless tobacco) Pipes	0.41			da.	200	٠ ،	1	_				<u>ب</u>		mark	ed	٦
SECTION II — Mark each item (11 through "Yes" must be explained in:	y4) the l	REI	es or No. It you MARKS section on th	ne re	eve	rs	se.	101	. pa		. o. or item, led ve	. ,	viction. Greig item			
A. Does your family have a history of	т-	No	1			_		Yes	No	c	(Contd.) Have you	ever	had or de you now h	140	Yes	No
11 Diabetes or sugar diabetes	 	X	35 Eye trouble (exclud					T	П	64	Back pain or troubl	•				X
12 Heart trouble or strokes	\top	X	lenses)						[x	65	Paralysis, lameness.	, or v	veakness		_	X
13 High blood pressure	1	X	36 Vision change or do	ouble	V(5)	on	n	T	X	66	Foot trouble]	X	
14 Cancer	T	X	37 Hearing loss						Х	67	Rheumatic fever					X
15 Mental condition	T	X	38 Ear, nose, or throat	trou	ble	_		$oldsymbol{oldsymbol{\Gamma}}$	Х	68	Tuberculosis or pos	itive	TB test			X
16 Alcoholism or suicide	T	x		ouble				L	X	69	Homosexual activit	y				X
17 Seizures or epilepsy	\top	X	40 Hay fever or allergi	ic thii	nitis			$oldsymbol{\mathbb{T}}$	X	70	VD, syphilis, gonori	rhea	, herpes, etc.			X
18 Allergies or Asthma	Τ	X	41 Severe tooth or gur	m tro	ouble			X	\Box	71	Skin conditions suc	h as	acne, psoriasis.	I		
19 Arthritis or rheumatism	Ι	X	42 Thyroid trouble						Х	L	hand or foot rashes	s, ec	rema, or dry skin		_	X
B. De you or did you ever	Ş.,		43 Chronic cough or lu	ing d	isea	se.	·	Ι	Х	72	Adverse reaction to			I		,
20 Wear glasses	Ι	Ţχ	44 Asthma or wheezing	19					X	L	medicine, food, or	Dite:	or stings			X
21 Wear contact lenses or ocular eye	Τ	Τ	45 Unusual shortness of	of br	eath	_			X	73	A weight problem				_	X
retainers	X	1	46 Pain or pressure in	chest	•	_		\bot	X	-	Recent gain or loss	_			_	X
22 Have any allergies	X		47 Palpitation or pour	nding) hea	n	1	\perp	X	75	Excessive bleeding	or e	asy bruising			X
23 Take any medications regularly	Ι	7	48 Heart trouble or he	eart r	murr	n	ur		X	-	. Tumor, growth, cy					X
24 Stutter or stammer	\perp	X	49 High blood pressur	e					Х	₽	Considered or atte	_	ed suicide			X
25 Wear a bone or joint brace or	T		50 Coughed up or von	nited	bio	00	d		X	-	Sleepwalking episc	odes			_	X
support	L	}	51 Stomach, liver, or ii	ntest	tinal	tr	rouble	\bot	Х	-	Easy fatigability				_	X.
C. Have you ever had or do you now have			52 Galibladder trouble	e or e	gails	to	ones	\perp	X	+-	Car, train, sea, or a				X.	-
26 Frequent, severe, or migraine			53 Yellow jaundice or	_		_		4-	X	1	1 X-ray or other radi	atio	n therapy		Н	<u>X</u>
headaches	\perp	12		ctald	isea	**	·	4	X	4 "	Sensitivity to chem	ncai:	s, dust.			i-
27 Fainting or dizzy spells	\perp	12						\perp	X	•	sunlight, etc					X
28 Periods of unconsciousness	X	-	56 Frequent or painfu	d urii	natio	200	<u> </u>	-	X		3 Learning disabilitie					X
29 Head injury or skull fracture	X	+-	57 Bed wetting since of			_		+	X	1	D. FEMALES ON	LY -	Have you ever N/A			
30 Epilepsy, seizures, or convulsions	\perp	13		suga	יחי	Jf (ine	+	X	1	 Been treated for a painful periods, or 					
31 Loss of memory or amnesia	1	13	59 Kidney stone					+	X	-		_			\vdash	\vdash
32 Depression, excessive worry or		1.	bù Hernia or rupture		nder '	_		+	\X	+-	 Had a change in m Been pregnant or 	_			\vdash	\vdash
nervousness, anxiety	+	-	X 61 Any bone or joint ! X 62 Broken bones or a					+	X X	+					+-	H
33 Any mental condition or illness	+	_	<u>`</u>			_		+	╁	1°	 faxen birth control dates and product 					
34 Frequent trouble sleeping		٠.			_	_			10						Y es	N
	f. Have you ever															
88. Been refused employment or been unable to hold or stay in school because of	or stay in school because of X pension or compensation for existing disability 2 X															
a inability to perform certain movements?				⊢	X	ľ	92 Had or have you operations?	ever b	een .	4GVI	ned to nave, any surg	rcal				k
b Inability to assume certain positions?				╀	X	ł					aus boratele ab				\vdash	f
< Other medical reasons?				\vdash	X	ľ	 Consulted or been nealers, or other 				nics, hospitals, physic or other than minor il					k
89 Been rejected for or discharged from military servi because of physical, mental or other reasons?	r e				v	ŀ				-					\vdash	f
				+	X	1	94 Had any illness of	r injur	, th	er tr	han those stready not	ed'			1	k
90 Been denied or rated up for life insurance?					١Ă.	L									_	÷

REMARKS (Every "Yes" response in items 17 through 36 must be exp status of the condition. Continue on a separate sheet and attach to this	iplained in the space below. Give dates and complete details including names of doctors an is form if additional space is needed)	id hospitals or clinics and the current
#21 Wears hard contact lenses.		
#22 Allergiesgrass, hay and	dust.	
#28 and 29 Concussion while pl	aying football - knocked out. Seen in em	ergency room at
Luke General Hospita	al, Lloyd NY, September 1982, Dr Jones.	
#66 Flatfeet. Treated with or	1983. No problem since. Dr Fix, Main St thotics when participating in sports. Se	reet, Aspen CO.
Force MA - 1984.		on by bi Julies,
#80 Car sickness in childhood.	I've outgrown it. No treatment.	
I certify that I have reviewed the foregoing information of the doctors, hospitals, or clinic mentioned above to	on supplied by me and that it is true and complete to the best of my o furnish the Government a complete transcript of my medical recor	knowledge. I authorize any difor purposes of processing
of the doctors, nospitals, or clinics mentioned above to my application for this employment or service.	5.5 Constitution of the second	_ or harbores or brocessing
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED
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HARRY G. MORAY	Harry H. Maron	10 Dec 88
	HARRY H. Maray D MARK ENVELOPE TO BE OPENED BY MEDITAL PERSONNEL OF	10 Dec 88
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MORAY LISA A.						_	ľ	01	11-11-0001				(10		962-0001			
				ACILITY OR EXAM: C HANSCOM, H									e)		DATE OF EXAM 5 May 87	ITANIN	ON	
SECTION ! - Mark applicable boxes in its	ms	1 t	thr	ough 10		_		_					· · · · · · · · · · · · · · · · · · ·		<u> </u>		_	_
1. How would you rate your present hea						_	Te	<u>-</u>	If you smoke cit	gare	ette		how many do yo	IL SI	noke each day?			
X Excellent Very Good Good	Т	_	Fa	Poor		_	X	_	Less than 1 pack	_	SACR.	_	1-1/2 packs	T	2 packs or more			
2. How many hours sleep do you usually	aet	at	ni	aht?			17	_			_	m		- I	do you drink any	alcoh	alic	
4 or less 5 6 7 X 8	Ť	_	_	or more		_	1	•	beverages such	1 45	bee	r,	wine, or liquor?		oo you umik any	B 10110	J.,(
3. How many days per week do you exer						_	T	প্	Never (skip to Item 9)	i e	ss th.	an	Once or	L	Three or four	Fixe	01	
		_	_			_	8	J	When you drink	k, he	w	m	any alcoholic dri	nks	do you have con t	he avera	gei?	
None 1 2 3 X 4	<u></u>	\perp	5	6 7			╁	Д,	<u>: </u>	12			3	L	4 5	6 01	mo.	*
4. Are you on any special diet?			_				 9	_	Amphetamines	_		ŕ	of the following	17	N/A			
5. Indicate the tobacco products you curre					_		╂	+	Cocaine	+-	rbitu	_		╀	Chemical inhalants			
X C garettes Cigars	en (i	T	Ť	Chewing tobacco		_	╁	_	What is your ma	_	Huci			1_	Narcotic drugs			
Shuff (Smokeless tobacco) Pipes		t	┪	None (Skip to Item 7)	-	-	k		Never Married	_	arries	_	Separated	_	Divorced	T.W.,	lowe	_
	QA	١	<u> </u>		do		<u></u>	٠.		_				<u></u>				_
SECTION II — Mark each item (11 through "Yes" must be explained in	the	RE	М	IARKS section on th	161	re	ver	se	the answer	101	e p.	•	(icular item, leav	en	olalik. Every iter	n mark	ea	
A. Does your family have a history of	٧e	, N		C. (Contd.) Have you	446	- h	ud c	or d	do you now have	Ve.	No	T	Contd.) Have you		r had or do you now h	440	Yes	
11 Diabetes or sugar diabetes	1	b	7	35 Eye trouble (exclud		_				T	1	-	54 Back pain or troub		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		H	X
12 Heart trouble or strokes	Τ	b	7	lenses)	. ,	-					X	ħ	55 Paralysis, iamenes	s. or	weakness		t –	X
13 High blood pressure	1	ĺχ	7	36 Vision change or do	duc	ev	*15101	_		\top	X	t	6 Foot trouble				x	Ë
14 Cancer	1	ľx	7	37 Hearing loss		_		_		\top	X	t	7 Rheumatic fever				<u> </u>	Х
15. Mental condition	Т	x	7	38 Ear, nose, or throat	tro	ub	,i e			1	X	t	8 Tuberculosis or po	sitivi	e TB test		<u> </u>	Х
16 Alcoholism or suicide	T	lx	7	39 Sinusitis or sinus tro	oubi	•				1	X	t	9 Homosexual activ	ty				Х
17. Seizures or epilepsy	T	x	7	40. Hay fever or allergic	c rh	'n	213			Τ	X	Ī	70 VD, syphilis, gono	rhea	, herpes, etc		Г	X
18 Allergies or Asthma	Т	Х		41 Severe tooth or gun	m tr	ou	ble			X	Г	Ī	71 Skin conditions su	ch as	ACRE, OSOCIASIS			Х
19 Arthritis or rheumatism	Т	Х		42 Thyroid trouble		_				Τ	Х	1	hand or foot rash				l	
8. Do you or did you ever		Ι		43 Chronic cough or lur	ng c	d154	ease	,		Ι	Х	Ī	Z Adverse reaction	o se	um, drugs,			Г
20 Wear glasses	L	X		44 Asthma or wheezing	g	_					Х	l	medicine, food, or					X
21 Wear contact lenses or ocular eye	Т	I	Į	45 Unusual shortness o	of br	rea	th				Х	ŀ	3 A weight problem					Χ
retainers	X	L	_	46. Pain or pressure in c	ches	A		_		L	X	L	4 Recent gain or los	of e	veight			Х
22 Have any altergies	X	╀	_	47 Palpitation or pound		<u> </u>		_		$oldsymbol{oldsymbol{oldsymbol{oldsymbol{\bot}}}$	X	L	5 Excessive bleeding	or e	asy bruising			X
23 Take any medications regularly	↓_	X	Ц	46 Heart trouble or hea	art	mı	2f Mu	ır		┖	X	Ŀ	6 Tumor, growth, cy	st, o	rcancer			X
24 Stutter or stammer	↓.	X	4	49 High blood pressure	•					┺	X	Ľ	7 Considered or atte	mpt	ed suicide			Х
25 Wear a bone or joint brace or	1		1	50 Coughed up or vom				_		_	X	₽	8 Sieepwalking epis	odes				Х
nogaut	322	X	_	51 Stomach, liver, or in	_			_		╄	X	₽	9 Easy fatigability				_	Х
C. Heve you ever had or do you now have	ļ.,	F	4	52 Galibladder trouble		_		nes	3	╀	X	١.	O Car, train, sea, or:				X.	Ц
26 Frequent, severe, or migraine headaches		L	ŀ	53 Yellow jaundice or h 54 Hemorrhoids or rect		_				╄	X	ľ	1 x-ray or other rad	atio	n therapy		-	Х
27 Fainting or dizzy spells	+	₹.	+	55 Black or bloody stoo	_	3154		_		┿	X	ľ	32 Sensitivity to chen sunlight, etc	nicals	, dust,			
28 Periods of unconsciousness	+,	X	+	56 Frequent or painful	_		1,00	_		+	X	1	3 Learning disabiliti		speech grobings		H	Ж
29 Head injury or skull fracture	+	+	┪	57 Bed wetting since ac		_		_		╁	X	k	D. FEMALES ON				9	X
30 Epilepsy seizures, or convulsions	+	۲	╁	58 Blood, protein, or su	_	_	_	00		+	X	f	·-··				-	Н
31 Loss of memory or amnesia	+	╁	ð	59 Kidney stone		_		_		╁	X	ľ	34 Been treated for a painful periods, or					v
32 Depression, excessive warry or	+	十	4	60 Hernia or rupture		_		_		+-	X	t	15 Had a change in m	_			├-	X X
nervousness, anxiety	1	1.	ν	61 Any bone or joint tr	rout		. bu	1511	tis	+	x	+	6 Seen pregnant or				┢	X
33 Any mental condition or illness	+	T	χ	62 Broken bones or am					····		X	t	7 Taken birth contro				\vdash	X
34 Frequent trouble sleeping	\top	۲.	χ	63 Steel pins, plates, or	/ 51 d	901	es in	1 00	ny bones		ĺχ	ľ	dates and product					l^
E. Have you ever		_	4	·····	/ es	_	_	-	(Contd.) Have you e			•					765	,
88. Been refused employment or been unable to hold a	ıob					Γ	┱		Received, is there po		a 0	, h	ave you applied for		· · · · · · · · · · · · · · · · · · ·		-	x
or stay in school because of:				_		х			pension or compens									ľ
a Inability to perform certain movements?	72 May at the you ever been burned to have, any surgical																	
b inability to assume certain positions?						×	_		operations?								Ĭ	x
c. Other medical reasons?						Х	J						nics, hospitals, physic					Γ
89 Been rejected for or discharged from military service	, _					ĺ	L		healers, or other pro	ctiti	oner	31	or other than minor if	ness	es7		L	x
because of physical, mental or other reasons?]	Х	٦,)4	Had any illness or in	juru .	othe	, ,	han those already nut	rd'			Γ	Γ
90 Reen denied or risted up for life insurance?						X	Ľ			, 1	J	Ċ					L	k

REMARKS (Every "Yes" response in items 11 through 94 must be ex- itatus of the condition. Continue on a separate sheet and attach to this	form if additional space is needed.)	1
		į.
#21 Wear soft contact lenses. #22 Allergiesgrass, hay and	dust.	
#22 and 29 Concussion while pl	aying softball - knocked out. Seen in	emergency room at
George General Hos	spital, Rome NY, July 1985, Dr Henry.	
#41 Treated for gingivitis in	1982. No problem now. Dr Gabelman, E	lm Street, Vail CO.
#66 Flatfeet. Treated with or	thotics when participating in sports.	Seen by Dr Williams,
Salem MA.		
#90 Car sickness in childhood.	I've outgrown it. No treatment.	
		ļ
		1
		i
		1
I certify that I have reviewed the foregoing informati	on supplied by me and that it is true and complete to the best of	my knowledge. I authorize any
of the doctors, hospitals, or clinics mentioned above t	to furnish the Government a complete transcript of my medical r	ecord for purposes of processing
my application for this employment or service.		
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED
	The stant	11. Kkc. 88
LISA A. MORAY	dua A Moray	11. Lete St
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE	D MARK ENVELOPE TO BE OPENED BY MEDICAL PERSONNE	L OMLY"
NOTE: HAND TO DOCTOR OR MURSE OR IF MAILE	I DESTRUCE THAT A SERVICE that comment on all "Yes" and black around	rs (indicating the item number before each
NOTE: HAND TO DOCTOR OR NURSE OR IF MARE EXAMINER'S SUMMARY AND ELABORATION OF All Comments, develop by interview any additional medical history deeme form.)	LL PERTINENT DATA (Examiner shall comment on all "Yes" and blank around important, and record significant findings here. If additional space is needed, con	L ONLY" It (indicating the item number before each tinue on a separate sheet and attach to this
NOTE: HAND TO DOCTOR OR NURSE OR IF MARE EXAMINER'S SUMMARY AND ELABORATION OF All comment), develop by interview any additional medical history deeme form.)	LONGOS ROMOVED 22 days prior to exam.	L ONLY" It (indicating the Nem number before each tinue on a separate sheet and attach to this
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AFR160-13/AR40-29/NAVMEDCOMINST6120.2A/CGCOMDTINSTM6120.8B Attachment 3 20 October 1989

DOD MEDICAL EXAMINATION REV	itu co	ant ude	ential use only and will not be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	e e	aved to unauthorized per	STO	RY)		OMI	# No	proved 0704-0769 ep 30, 1989			7
(This form is subject NAME (Last First Middle Initial)	(This form is subject to the Privacy Act of 1974 - See DD Form 2005) SOCIAL SECURITY NUMBER TELEPHONE NO. (Include area code)														
The second secon			CILITY OR EXAMINE	Ļ	Ļ	O ADDRESS Harbor	to 7:0	C 04	4 5)	L		DATE OF EXAM	INATIO	N	┨
PURPOSE OF EXAMINATION EXAMINAT	IUN		CILITY OR EXAMINE		~"	·	× 14		~,		١				1
SECTION I - Mark applicable boxes in item	<u> </u>	thre	ough 10												1
How would you rate your present healt!					6.	. If you smoke ciga	aret	tes	how many	do you	ı sm	oke each day?]
Excellent Very Good Good	ËΠ	Fai	ır Poor		Г		1 pac	_	1-1/2 p			2 packs or more			1
2. How many hours sleep do you usually g	et a	t nic	aht?	7	7	. On the average,	how	m	any times	per wee	ek d	o you drink any	akohol	ic	٦
4 or less 5 6 7 8	ΪŤ		or more	\exists		beverages such a	as be	er	, wine, or li	dnot					J
3. How many days per week do you exerci					Г	Never (skip to item 9)	Less	thar	Once of	ы	П	Three or four	five o	or	٦
(enough to produce a sweat) for at least fifteen	mi	nut	es		a	. When you drink,		v 11		olic drin	_		_	_	٦
None 1 2 3 4	П	5	6 7		Ė	1.	2		3			4 5	6 or 1		
4. Are you on any special diet?	_				9	. Have you ever u	sed	any	y of the foll	owing?	,				
Yes No					Г	Amphetamines	Barb	tur	a.es			Chemical inhalants			
5. Indicate the tobacco products you curren	ntly	use			Г	Cocaine	Halle	KIM	ogens			Narcotic drugs			
Cigarettes Cigars	竹	П	Chewing tobacco		ī	0.What is your mai	rital	sta	itus?						
Snuff (Smokeless tobacco) Pipes	\neg	П	None (Skip to Item 7)		Г	Never Married	Mar	ried	Separ	ated		Divorced	Wide	o ≁ed	
SECTION II - Mark each item (11 through	94)	~Ye	s " or "No " If you do	n	ot	know the answer f	or a	pa	rticular iter	n, leave	e it l	olank. Every item	n mark	ed	٦
"Yes" must be explained in t	he f	REM	IARKS section on the r	ev	/er	se.		•							
A. Does your family have a history of	Yes	No	C. (Contd.) Have you ever	rhi		or do you now have	46	₩	C. (Contd.)	Have you	***	had or do you now h	240	Yes	٧o
11 Diabetes or sugar diabetes	۳	-	35 Eye trouble (exclude gi	_			\Box	┪	64 Back pain	or troubl	le			П	٦
12 Heart trouble or strokes	┪	Н	lenses)	-42	.	Compet			65 Paralysis.	lameness	, or v	veakness			٦
13 High blood pressure	╁	Н	36 Vision change or double	ev	ısıo	n	\Box		66 Foot trou	ble					٦
14 Cancer	┢	Н	37 Hearing loss		_		Н	╗	67 Rheumat	ic fever				T	٦
15 Mental condition	╁	Н	38. Ear, nose, or throat troe		ie		Н	_	68 Tubercul	osn or por	utive	TB test		1	┨
16 Alcoholism or suicide	╁	Н	39 Sinusitis or sinus trouble	_	-		H	┪	69. Homosex	ual activi	ty				٦
	╁	Н	40 Hay fever or allergic rhi		tis		H	┪	70 VD, syphy	ilis, gonor	rhea	, herpes, etc			٦
17 Seizures or epilepsy	╁╌	Н	41 Severe tooth or gum tr				H			4 410				\dashv	╛
18 Allergies or Asthma	╁╴	Н	42 Thyroid trouble				\vdash	\neg				acne, psoriasis, rema, or dry skin	1		
19 Arthritis or rheumatism	72.0		43 Chronic cough or lung of	dis			╁┤	\dashv						\Box	
8. Do you or did you ever	- ***		44 Asthma or wheezing				Н	-	72 Adverse medicine	reaction t , food, or				l	
20 Wear glasses	╁	⊢	45 Unusual shortness of b	-			Н	-	73. A weight	t problem				\dashv	┪
21 Wear contact lenses or ocular eye	1	1	46 Pain or pressure in cher		••••		Н	Н	74. Recent g			reight		H	┪
retainers	╀	╀	47 Palpitation or poundin	_	-		Н	Н	75 Excessive		_			H	
22 Have any allergies	╄	╀	48 Heart trouble or heart	_			Н	_	76 Tumor, g		_			H	\neg
23 Take any medications regularly	╁	┼	49 High blood pressure				Н	Н	77 Consider				-	Н	\neg
24 Stutter or stammer	╀	╀		4 6	-	<u> </u>	\vdash	-	78 Sleepwa		_			Н	\exists
25 Wear a bone or joint brace or		1	50 Coughed up or vomited 51 Stomach, liver, or intes	_			╁		79 Easy fati			· · · · ·		Н	П
support		3300		_	_		╁╌	H	80 Car, trail		847 34	kness		Н	П
C. Have you ever had or do you now have	-	§	52 Gallbladder trouble or				╁╌	⊢	81 X-ray or					П	П
26 Frequent, severe, or migraine	1		53 Yellow jaundice or hep 54 Hemorrhoids or rectal				┰	\vdash	 					Н	П
headaches	+	╁	55 Black or bloody stools	311			+	\vdash	82 Sensitivi sunlight		THEAT	s, gust,		l l	
27 Fainting or dizzy spells	+-	+	56 Frequent or painful ur				╁	\vdash	<u> </u>		162 01	speech problems		Н	П
28 Periods of unconsciousness	+-	╁			_		+	-			_	Have you ever		22	3
29 Head injury or skull fracture	+	+	57 Bed wetting since age				+-	\vdash							ئسر
30 Epilepsy, seizures, or convulsions	╀	+	58 Blood, protein, or suga	41			+	╁		eated for a periods, o		nale disorder, mps		H	l
31 Loss of memory or amnesia	╁	╀	59 Kidney stone	-			+	╁			_	rual pattern		T	Г
32 Depression, excessive worry or						w.rest.s	+	\vdash				you now pregnant		T	Г
nervousness, anxiety	+	+	61 Any bone or joint trau 62 Broken bones or ampu	_			+	t						T	T
33 Any mental condition or illness	+	+	63 Steel pins, plates, or st	_			+	t		urth contr nd produc		is (If yes, gove nes)		١	
34 Frequent trouble sleeping				_	_				1					75	N.
E. Have you ever				1	끡	E. (Contd.) Have you					_			†	r
88 Been refused employment or been unable to hold a or stay in school because of:	, job					91. Received, is there p pension or compen	satio	ng. o	or have you apt r existing disab	pired for ulity?				L	L
a inability to perform certain movements?				I		92 Had, or have you e	ver b	ren .	advised to have	e, any sur	gecal			1	
b inability to assume certain positions?				Ι		operations?								┺	1
c Other medical reasons?				I		93. Consulted or been	trest	ed b	y clinics, hospit	tals, physi	KIANS			1	1
89 Been rejected for or discharged from military servi	æ			T		healers, or other pr	ractit	one	ers for other th	an minor i	HINES	MO1		Ļ .	Ļ
because of physical, mental or other reasons?				+		94 Had any illness or i	ulari	oth	er than those a	elready no	oted?			-	
90 Been denied or rated up for life insurance?				_1										-	_

AFR160-13/AR40-29/NAVMEDCOMINST6120.2A/CGCOMDTINSTM6120.8B Attachment 3 20 October 1989

REMARKS (tivery "Yes" response in items 17 through 3d must be e status of the condition. Continue on a separate sheet and attach to th	splained in the space below. Give dates and complete details including names of c	factors and heispitals or eli	mics and the livere
	pace is recovery		
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I certify that I have reviewed the foregoing information	on supplied by me and that it is true and complete to the best	of my knowledge	authorize any
or the doctors, hospitals, or clinics mentioned above to my application for this employment or service.	o furnish the Government a complete transcript of my medical	record for purpose	es of processing
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ITPED OR PRINTED NAME OF FXAMINES	SIGNATURE	DATE CICH	(0)
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		DATE SIGN	
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILEE EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form J	MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONN L PERTINENT DATA (Examiner shall comment on all "Yes" and blank any important, and record significant findings here. If additional space is needed, co	IEL ONLY" vers (indicating the item intimue on a separate sheet	number before each it and attach to this
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED EXAMINER'S SUMMARY AND ELABORATION OF AL	MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONN	IEL ONLY"	number before each of and attach to this
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILEE EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form) TYPED OR PRINTED NAME OF PHYSICIAN	MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONN L PERTINENT DATA (Examiner shall comment on all "Yes" and blank any important, and record significant findings here. If additional space is needed, co	IEL ONLY" vers (indicating the item intimue on a separate sheet	number before each it and attach to this

DD Form 2492 Reverse, MAR 87

DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION

	DOD MEDICAL EVANNATION DEV	1714 POARD (DORAGE)							
DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION									
	Privacy Act State	ement							
AUTHORITY:	10 USC 8012 and Executive Order 9397.								
PRINCIPAL PURPOSE:	To update a medical file as part of the al Reserve Officer Training Corps (ROTC University of Health Sciences (USUHS).	pplication process to a United States Service Academy,) Scholarship Program, or the Uniformed Services							
ROUTINE USES:	Used to determine medical acceptability	r for one or more of the Service Academies, ROTC, or authorized personnel involved in the selection process. for positive identification							
<u>DISCLOSURE</u> :		the requested information will impede the selection							
1. APPLICANT'S NAME (Last.)	First, Middle Initial)	2. SSN							
JONES, HARRY W.,	JR.	100-01-0001							
John John John John John John John John									
Colorado Springs, Co 80840-6	d 53N. Expedite completed Dental Examination with 518.	mic and bitewing radiographs must accompany this examination completed Medical Examination to: DODMER8/DB, US Academy,							
3. INDICATE ON THE CHART MISSING TEETH, TEETH REPI ABNORMALITIES. (Do not chart r	BELOW, RESTORABLE, NON-RESTORABLE, LACED, SPACES CLOSED AND ANY DEFECTS OR restorations)	4. TYPED OR PRINTED NAME OF EXAMINING DENTIST MARK V. ALLEN, D.D.S.							
	A A A								
MANA	A A A A A A A A A A A A A A A A A A A	5. SIGNATURE OF EXAMINING DENTIST 6. DATE SIGNED Clansq							
MENCE		7. EXAMINING FACILITY a. NAME							
RIGHT - 3 4 5	6 7 8 9 10 11 12 13 14 15 16	Vandenberg Dental Clinic							
		b. ADDRESS USAF Clinic/SGD Vandenberg AFB CA 93437-5300 NOTE if examinee has a questionable occlusal relationship, forward diagnostic casts to:							
100000	NAAAAAAAAAA	DODMERB/DB US Academy Colorado Springs, CO 80840-6518							
B. GENERAL ("X" Yes or No for eac	ch question)								
YES NO	EC								
h MISSING TEET	ES (Indicate on chart, do not chart incipiencies): "H, OTHER THAN THIRD MOLARS (indicate on chart by ma	**************************************							
	ABLE TEETH (indicate on chart by drawing two vertical lines through								
	FEETH (draw circle around the tooth on the chart and indicate position								
	TAL DISTURBANCES IN TEETH (significant enamel hypoplas								
	TH (intrinsic) (unsightly).	•							
HISTORY OF ORAL DISEAS ("X" Yes or No for each question. If	E, TUMOR OR ANY OTHER ABNORMALITY OF THE additional space is needed use "REMARKS" section)	ORAL CAVITY							
y a. HAS THE EXA	MINEE EVER HAD A CYST OR TUMOR REMOVED F	ROM THE MOUTH OR JAWS? (If an describe)							
	ABNORMAL BLEEDING OF THE ORAL TISSUES. (Descri								
	TIONS, SOFT TISSUE LESIONS, ETC. (Describe)								
X d. HISTORY OF C	CLEFT LIP								
X e. HISTORY OF C	CLEFT PALATE.								
X (1) If yes, is the	ere an oro-nasal or oro-antral fistula present?								
	f. HISTORY OF TMJ DISEASE OR PAIN. (Describe)								
Continued on reverse side)									

		_					
		Αl	RELATIONSHIP ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)				1
YES		_					
	X		ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm				1
	X	b.	ANTERIOR OVERBITE IN EXCESS OF 4mm				1
	X	C.	ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.				1
		d	SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIO	OR 1	TEETI	4	1
	X	•	INTO THE LOWER LABIAL GINGIVAE				l
	X	۵	ANTERIOR CROSSBITE. (Describe)				
	1		MANDIBULAR PROGNATHISM.				
	X X						
	X	_	POSTERIOR OPEN BITE (bilateral involving more than one tooth).				i
	X		POSTERIOR CROSSBITE (entire quadrant)				
	X	١.	UNSIGHTLY CROWDING OF THE ANTERIOR TEETH				1
	X	j.	MULTIPLE CONGENITALLY MISSING TEETH.				- 1
X		k.	MIDLINE DEVIATION. 2 mm				1
	Х	1.	ARE DENTAL STUDY CASTS BEING FORWARDED?				
11.	ORTHO		INTICS ("x" Yes or No for each question)				
Х	I	a.	PAST HISTORY OF ORTHODONTIC TREATMENT (detecompleted) June 87				l
<u> </u>	X	Ь.	PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable)				:
X	+^-		WEARING RETAINER APPLIANCES. 21 thru 27 fixed retainer				
Α_	لــــــــــــــــــــــــــــــــــــــ	٠.	Weaning Relation as Courses				
12.	PROSTI	10	DONTICS ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)				
	х		MISSING TEETH (prosthesis required). (Describe)				l
	Х	ъ.	MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (Describe)				1
	y	c.	ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?				
13.	PERIOD	O	ITAL STATUS ("x" Yes or No for each question)				
<u> </u>	T v	ه ا	MODERATE TO HEAVY CALCULUS (supra and or sub-gingival)				
	X	i .	GINGIVITIS (generalized)				
_	<u> </u>	1	•				
	<u> </u>	ŀ	ACUTE NECROTIZING ULCERATIVE GINGIVITIS				
	X		LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss).				- 1
	X	e.	JUVENILE PERIODONTITIS.				- 1
	X	f	PERICORONITIS.				
14.	PANOG	RA	PHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)				
 	Х	۵.	ABNORMAL RADIOLUCENT/RADIOPAQUE AREA. (Describe)				
\vdash	+	1	IMPACTED TEETH WITH PATHOLOGY. (Describe)				- 1
	X						
	X	4	IMPACTED TEETH OTHER THAN THIRD MOLARS (Describe)				ĺ
<u> </u>	X	d.	OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)				
15.	OTHER	Al	BNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. ("X" Yes or No)				
	X	l					
16.	REMAR	KS	(Indicate item of reference) (Use additional sheet if necessary)	1	000		
1 2	la D.	. t	ient needs prophylaxis and scaling.		USE	ON	.Υ
l ''	, a		Tour mann broken america and area of		T	T	
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DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERS) REPORT OF DENTAL EXAMINATION							
	Privacy Act Staten	nent					
AUTHORITY:	10 USC 8012 and Executive Order 9397.						
PRINCIPAL PURPOSE:	17 1 51						
ROUTINE USES:	Used to determine medical acceptability to USUHS, Information will be released to au The Social Security Number (SSN) is used for	thorized p or positive i	ersonnel involved in the sel dentification.	ection process.			
DISCLOSURE:	Voluntary; however, failure to furnish the process and hamper your candidacy.	ne request		e the selection			
1. APPLICANT'S NAME (Last.)	irst, Middle Initial)	;	2. SSN	!			
			<u> </u>				
To be completed at scheduler and be identified by name an Colorado Springs, Co 80840-6	INSTRUCTIONS d Examining Center by the Examining Dentist. Panoram id SSN. Expedite completed Dental Examination with co 518.	nic and bitew ompleted Me	ing radiographs must accompany t dical Examination to: DODMERB/(his examination DB, US Academy,			
MISSING TEETH, TEETH REP	T BELOW, RESTORABLE, NON-RESTORABLE, LACED, SPACES CLOSED AND ANY DEFECTS OR	4. TYPED O	R PRINTED NAME OF EXAMINING	3 DENTIST			
ABNORMALITIES. (Do not chart	restorations)						
alala	ALAAAAAAAAA		IRE OF EXAMINING DENTIST	6. DATE SIGNED			
1 2 3 4 5	6 7 8 9 10 11 12 13 14 15 16	a. NAMI	ING FACILITY				
		b. ADDF	RESS				
	700000000000000000000000000000000000000	MOTE (f examinee has a questionable occlusal relationship, forward diagnostic casts to DODMERB/DB US Academy Colorado Springs, CO 80840-6518					
8. GENERAL ("X" Yes or No for e	nech question)						
YES NO a. DENTAL CARIES (Indicate on chart, do not chart inciprencies). b. MISSING TEETH, OTHER THAN THIRD MOLARS (indicate on chart by marking "X" through the roots). c. NON-RESTORABLE TEETH (Indicate on chart by drawing two vertical lines through tooth). d. UNERUPTED TEETH (draw circle around the tooth on the chart and indicate position by an arrow).							
	ENTAL DISTURBANCES IN TEETH (significant enamel hypople EETH (intrinsic) (unsightly).	isias, amelogenes	is imperfects, dentinogenesis imperfects, etc.	,			
9. HISTORY OF ORAL DISE	ASE, TUMOR OR ANY OTHER ABNORMALITY OF TH	E ORAL CAV	ITY				
	XAMINEE EVER HAD A CYST OR TUMOR REMOVED		MOUTH OR JAWS? (# so, describe.)				
	b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES. (Describe)						
	RATIONS, SOFT TISSUE LESIONS, ETC. (Describe)						
d. HISTORY O	F CLEFT LIP F CLEFT PALATE.						
	there an oro-nasal or oro-antral fistula present?						
	F TMJ DISEASE OR PAIN. (Describe)						
(Code and on coverage (de)							

10. OCCLUSAL RELATIONSHIP ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section) YES NO						
Ta ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm						
b. ANTERIOR OVERBITE IN EXCESS OF 4mm						
						
c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.						
d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH, INTO THE HARD PALATE, OR THE UPPER INTO THE LOWER LABIAL GINGIVAE	ANTERIOR TEETH					
e. ANTERIOR CROSSBITE. (Describe)						
f. MANDIBULAR PROGNATHISM.						
g. POSTERIOR OPEN BITE (bilateral involving more than one tooth).						
h. POSTERIOR CROSSBITE (entire quadrant)						
I. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH						
I. MULTIPLE CONGENITALLY MISSING TEETH.	J. MULTIPLE CONGENITALLY MISSING TEETH					
k. MIDLINE DEVIATION.						
I. ARE DENTAL STUDY CASTS BEING FORWARDED?						
11. ORTHODONTICS ("X" Yes or No for each question)						
a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed).	· · · · · · · · · · · · · · · · · · ·					
b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable).						
c. WEARING RETAINER APPLIANCES						
12. PROSTHODONTICS ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section.)						
a. MISSING TEETH (prosthesis required). (Describe)						
b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (Describe)						
c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?						
13. PERIODONTAL STATUS ("X" Yes or No for each question)						
a. MODERATE TO HEAVY CALCULUS (supra and / or sub-gingival)						
b. GINGIVITIS (generalized).						
 						
c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS						
d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss).						
e. JUVENILE PERIODONTITIS.						
f. PERICORONITIS						
14. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section).						
a. ABNORMAL RADIOLUCENT/RADIOPAQUE AREA (Describe)						
b. IMPACTED TEETH WITH PATHOLOGY. (Describe)						
c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe)						
d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)						
15. OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. ("X"Yelor No)						
16. REMARKS (Indicate Item of reference.) (Use additional sheet if necessary.)	DODMERB USE ONLY					
	USE ONLY					
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ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2480

Explanation Model Entry Item 1. Applicant Name. (Last, First, MI) Jones, Harry W., Jr. Item 2. Social Security Number. 999-99-9999 Item 3. Indicate on the chart: Restorable, nonrestorable, miss-See item 3, attachment 4 ing teeth, teeth replaced, spaces closed and any defects or abnormalities. Do not chart restorations. Item 4. Typed or Printed Name of Examining Dentist. CHARLES P. WHITE, Maj, USAF, DC Items 5 and 6. Signature of Examining Dentist and Date of Self-explanatory Dental Examination. Item 7. Examining Facility and Address. USAF Clinic/SGD Vandenberg AFB CA 93437-5300 Items 8 through 15. A yes or no answer is required for each of See items 8 through 15, attachment 4 the questions. Write in additional information next to the question or in the remarks section (item 16). Item 16. Remarks. Indicate item of reference, use additional Item 13a. Patient needs prophylaxis and sheet if necessary. scaling.

DD FORM 2369, DOD MEDICAL EXAMINATION REVIEW BOARD CYCLOPEGIC REFRACTION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) CYCLOPLEGIC REFRACTION						
	Privac	cy Act Statement				
AUTHORITY:	Title 10, USC 122, and Execut	tive Order 9397.				
PRINCIPAL PURPOSE:	To upgrade a medical file as Officer Training Corps (ROT Health Sciences (USUHS).	part of the application proc C) Scholarship Programs, or	ess to the U	a US Service Academy, Reserve niformed Services University of		
ROUTINE USE:	ptability for one or more one released to authorized phumber (SSN) is used for position	ersor	service academies, ROTC OR nnel involved in the selection lentification.			
DISCLOSURE:	Voluntary, however, failure process and hamper your ca	e to furnish the requested in ndidacy.		ation will impede the selection		
1. NAME OF APPLICANT (Last.	First, Middle Initial)	2. SSN OF APPLICANT	3. DA	TE OF EXAMINATION		
SCARBOROUGH, JIMM		001-00-1000	5	May 87		
		l	S. PH	ONE NO. AT FACILITY (Include Area Code)		
4. ADDRESS OF FACILITY (GIN USAFA HOSPITAL/SGI	, State, Zip Code) >		1	303) 472–3577		
USAFA, CO 80840				THE TANK THE TANK		
6. CONTACT LENS DATA WAS			mei	MILY EYE HISTORY (Please indicate the imbers of your immediate family who wear glasses or		
X a. I do not wear contac		- to the choice over mination	X	tact lenses.) (X apolicable item(s)) a. Father		
b. Soft contact lenses w	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	r to the above examination	 ^ -	b. Mother		
c. Hard contact lenses v	, , ,	ir to the above examination	 	c. Brother		
d. Signature of Applica	nt		l x	d. Sister		
			 	e. None of my family		
O MICION SWALLIATION BEE	ORE INSTALLATION OF DROPS (Befor	re cyclonlegic)				
	THE INSTALLATION OF BROTS (BETO)	b. CURRENT RX N/A				
a. DISTANT VISION	Corr to 20/	OD Sphere Cyl		Axis		
OD 20/ 20		OS Sphere Cyl		Axis		
OS 20/ 20	Corr to 20/	9. MEDICATION USED FOR CYCL	OPLEG	C		
c. NEAR VISION	Corr to 20/	Cyclogel				
OD 20/ 20	Corr to 20/	0,010801				
OS 20/ 20		Correct to 20/20 absolute. Record number of let	ters misse	ed on 20/20, i.e., 20/20-2, 20/20-3 etc. If unable to		
10. VISION EVALUATION AFTI	able vision. Do not over correct, correct only to	20/20)				
a. DISTANT VISION CORRECT		b CYCLO RX				
	Corr to 20/ 15	OD Sphere +0.50 Cyl	-0.	50 Axis 088		
OD 20/ 50 OS 20/ 50	Corr to 20/ 15	OS Sphere +0.50 Cyl				
	any diagnosis which interferes with visual functi	ion which was noted on this examination)	MINER			
12. TYPED OR PRINTED NA		· · · · · · · · · · · · · · · · · · ·	σ			
ISSAC L. DOETOE,	CAPT, USAF, BSC	Li mar hat	~\/	DO COST WAT		

DD Form 2369, MAY 86

Previous edition will be used

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) CYCLOPLEGIC REFRACTION						
	Priva	cy Act Statement				
AUTHORITY:	Title 10, USC 122, and Execu	tive Order 9397.				
PRINCIPAL PURPOSE:				ess to a US Service Academy, Reserve the Uniformed Services University of		
ROUTINE USE:		be released to auth	orized p	f the service academies, ROTC OR personnel involved in the selection tive identification.		
DISCLOSURE:	Voluntary, however, failure process and hamper your ca	e to furnish the requindidacy.	uested in	formation will impede the selection		
1. NAME OF APPLICANT (Last, First, Middle Initial) 2. SSN OF APPLICANT 3. DATE OF EXAMINATION						
4. ADDRESS OF FACILITY (GI	ty, State, Zip Code)			5. PHONE NO. AT FACILITY (Include Area Code)		
6. CONTACT LENS DATA OLA	policable (tem(s))	-		7. FAMILY EYE HISTORY (Please indicate the		
a. I do not wear contac				members of your immediate family who wear glasses or contact lenses.) (X applicable item(s))		
b. Soft contact lenses v		r to the above examinatio	n .	a Father		
c. Hard contact lenses		r to the above examinatio		b Mother		
d. Signature of Applica				c. Brother		
1				d. Sister		
				e. None of my family		
8. VISION EVALUATION BEFO	ORE INSTALLATION OF DROPS (Befor	e ovlaaleax)				
a. DISTANT VISION		b. CURRENT RX				
OD 20/	Corr to 20/		Cul	Avie		
OS 20/	Corr to 20/	OD Sphere	Cyl	Axis		
c. NEAR VISION	Corr to 207	OS Sphere	Cyl	Axis		
		9. MEDICATION USED FOR CYCLOPLEGIC				
OD 20/	Corr to 20/	1				
O\$ 20/	Corr to 20/	<u> </u>				
			umber of lette	ers missed on 20/20, i.e., 20/20-2, 20/20-3 etc. If unable to		
	table vision. Do <u>not</u> over correct, correct <u>only</u> to					
a. DISTANT VISION CORRECT		b. CYCLO RX				
OD 20/	Corr to 20/	OD Sphere	Cyl	Axis		
O\$ 20/	Corr to 20/	OS Sphere	Cyl	Axis		
12. TYPED OR PRINTED NAI	any diagnosis which interferes with visual function	I 13. SIGNATURE		HMCD		
14. ITPEU OR PRINTEU NAF	ME OF EXAMINER	13. SIGNATURE	UP EXAM	HNCK		

DD FORM 2370, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE-DAY BLOOD PRESSURE AND PULSE CHECK

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE DAY BLOOD PRESSURE AND PULSE CHECK

Privacy Act Statement

AUTHORITY:

Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE:

To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of

Health Sciences (USUHS).

ROUTINE USES:

To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The

social security number (SSN) is used for positive identification.

DISCLOSURE:

Voluntary; however, failure to furnish the requested information will impede the selection

process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)

2. SSN OF APPLICANT

512-10-0000

MARTINEZ CATHERINE L

INSTRUCTIONS TO EXAMINERS

Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used.

3. ARM CIRCUMFERENCE 9"	4. WIDTH OF THE BLOOD PRESSURE CUFF	5. MEDICATION CL	5. MEDICATION CURRENTLY TAKEN (If none, so state.)		
,	14 cm	NONE			
6. BLOOD PRESSURE AND P	ULSE READINGS				
a DAY ONE					
(1) DATE	(2) A.M. 0700		(3) PM 1300		
5 May 87	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE	
(a) SITTING	136/80	80	140/86	88	
(b) RECUMBENT	138/78	78	130/80	80	
(c) STANDING	130/80	78	138/82	8	
DAY TWO		***			
(1) DATE 6 May 87	(2) AM 0715		(3) PM 1400		
0 1.a.y 07	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE	
(a) SITTING	120/80	80	130/70	76	
(b) RECUMBENT	120/76	76	126/70	76	
(c) STANDING	126/82	80	132/80	80	
. DAY THREE					
1) DATE 7 No. 97	(2) AM 0730		(3) P.M. 1500		
7 May 87	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE	
(a) SITTING	120/76	76	130/80	76	
(b) RECUMBENT	118/80	76	130/80	74	
(c) STANDING	124/80	80	136/86	80	
7. EXAMINER (Doctor/Nurse/Param					
TYPED OR PRINTED NAME MEDIC, JOHNNY D	(Last, First, Middle Initial)	B-SIGNATURE	I) moder	`	
AlC, Blood Pressu	ire Recheck Department		7		

DD Form 2370, MAY 85

	Ţ			CAL EXAMINATION BLOOD PRES		•	•	
				Privacy Act	Stateme	<u>nt</u>		
AUTHO	RITY:	Title 10), USC 133	, 3012, 5031, 8012 an	d Execut	ive Order 9	397 .	
	AL PURPOSE:		•				cess to a US Service A	Academy, Reserve
- TANTON	Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).							
ROUTIN	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.							
DISCLO!	DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.							
1. NAME	I. NAME OF APPLICANT (Last, First, Middle Initial) 2. SSN OF APPLICANT							
				INSTRUCTIONS T	O EXAM	INERS		
patient's may be	s arm. If it is t erroneously lo	oo narro w. For t	ow, the b the average 20 cm wid	lood pressure readin ge adult, a cuff 12 to de, must be used.	gs will b	e erroneou	ct width for the circusty high. If it is too w factory. For arm circu	vide, the readings
3. ARM CI	RCUMFERENCE			OF THE BLOOD RE CUFF	S. MEDI	CATION CURI	RENTLY TAKEN (If none, so sta	te.)
6. BLOOD	PRESSURE AND	PULSE RE	ADINGS	-				
a. DAY O	NE							
(1) DATE				(2) A.M			(3) P.M.	
				BLOOD PRESSURE		ULSE	BLOOD PRESSURE	PULSE
(a)	SITTING							
(b)	RECUMBENT							
(c)	STANDING							
b. DAY T	WO							•
(1) DATE				(2) A.M.			(3) P.M.	
				BLOOD PRESSURE	 	PULSE	BLOOD PRESSURE	PULSE
	SITTING				-			
(b)	RECUMBENT				<u> </u>			
	STANDING			<u> </u>	<u> </u>	· ·		
c DAY TI	HREE			Ten			Las and	
(1) DATE				BLOOD PRESSURE	F	PULSE	BLOOD PRESSURE	PULSE
(a)	SITTING							
(b)	RECUMBENT							
(c)	STANDING							
	MER (DoctorMurse/Far							
a. TYPED	OR PRINTED NAM	AE (Last, Fors	st, Middle Instal	0	b. SIGN	IATURÉ		
c TİTLE		·			.1		······································	

DD Form 2370, MAY 85

DD FORM 2371, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)							
	UPDATE OF APPLICANT'S N	MEDICAL EXAMI	NATION				
-	Privacy Act S	tatement					
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and	d Executive Order 9397					
PRINCIPAL PURPOSE:	To upgrade a medical file as part of to Officer Training Corps (ROTC) Schola Health Sciences (USUHS).	he application process irship Programs, or the	to a U.S. Service Academy, Reserve Uniformed Services University of				
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.						
DISCLOSURE:	Voluntary; however, failure to furni process and hamper your candidacy.	ish the requested info	rmation will impede the selection				
1. TYPED OR PRINTED NAI	ME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR				
LEWIS, JOHN D.	ļ	001-01-1001	US Naval Academy				
previous examination of the service		medical or dental statu or dental care since the	us for the current selection cycle.				
b. Detailed explanation why the statement in 4 above is not totally accurate (Attach additional pages, if necessary.) I had two wisdom teeth removed in Jan 86. I had arthoscopic surgery on my right knee in Nov 85. My knee is fine now.							
5. SIGNATURE OF APPLICA	the D Lennie		6. DATE SIGNED 6 May 87				

	DOD MEDICAL EXAMINATION R UPDATE OF APPLICANT'S N	EVIEW BOARD (DODMERB) MEDICAL EXAMINAT	TION			
	Privacy Act S	tatement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and	d Executive Order 9397.				
PRINCIPAL PURPOSE:	that the search of the application process to a U.S. Service Academy, Reserve					
To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.						
DISCLOSURE:	Voluntary; however, failure to furni process and hamper your candidacy.	sh the requested informati	on will impede the selection			
I. TYPED OR PRINTED NAI	AE OF APPLICANT (Lest, First, Middle Initial)	2. SSN OF APPLICANT 3. NA	IME OF PROGRAM APPLIED FOR			
	INSTRUCT	TONS				
Service Academy medi year's selection cycle. previous examination	f Defense Medical Examination Review cal examination report. Our records inc If there has been no change in your re eport as the basis for determining your	dicate that you were given a medical or dental condition medical or dental status for	, we may be able to use your the current selection cycle.			
 "I hereby certify to medical examinatia. The above statement 		or dental care since the dat	e of my Service Academy			
(1) IS TRUE AND	ACCURATE in all respects.					
(2) IS NOT TOTA	LLY ACCURATE (Explain in detail in 4b below	w.)				
	on why the statement in 4 above is not		onal pages, if necessary.)			
b. Detailed explories.	,,	•				
l						
5. SIGNATURE OF APPLIC	ANT		6. DATE SIGNED			
	ς					

DD FORM 2372, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH

	DOD MEDICAL EXAMINATION RE STATEMENT OF PRE		
	Privacy Act Sta	tement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and	Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the Officer Training Corps (ROTC) Scholars Health Sciences (USUHS).		
ROUTINE USE:	NE USE: To determine medical acceptability for one or more of the service academies, ROTC OR USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.		
DISCLOSURE:	Voluntary; however, failure to furnish process and hamper your candidacy.	the requested information	will impede the selection
1. NAME OF APPLICANT (Las	t, First, Middle Initial)		2. SSN OF APPLICANT
STEWART, ANN M.			001-02-1002
3. STATEMENT OF PRESENT	HEALTH		
Good.			
4. NAME OF MEDICATION(S) AND REASON FOR TAKING (If you are not on any kind	of medications, simply state *NONE *7	
Tetracycline for	my acne.		
5. DO YOU HAVE ALLERGIE	S? (Answer Yes or No. If yes, indicate treatment received; if n	o allergies, write "NONE")	
-			
6. REMARKS			
			:
<u> </u>			
7. SIGNATURE OF APPLICAN	7 0,-		8. DATE SIGNED
(lnn 7	n Stewart		6 May 87

DD Form 2372, FEB 86

Previous edition may be used.

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH				
	Privacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:					
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC OR USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish the requested information process and hamper your candidacy.	will impede the selection			
1. NAME OF APPLICANT (Last	First, Middle Initial)	2. SSN OF APPLICANT			
3. STATEMENT OF PRESENT	HEALTH				
4. NAME OF MEDICATION(S	AND REASON FOR TAKING (If you are not on any kind of medications, simply state "NONE")				
:					

5. DO YOU HAVE ALLERGIE	\$7 (Answer Yes or No. If yes, indicate treatment received, if no allergies, write "NONE")				
6. REMARKS					
7. SIGNATURE OF APPLICAN		8. DATE SIGNED			

DD FORM 2374, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) HEART MURMUR EVALUATION

		N REVIEW BOARD (DODMERS) UR EVALUATION	
	Privacy Ac	t Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012	and Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part o Officer Training Corps (ROTC) Sch Health Sciences (USUHS).	f the application process to a Uniolarship Programs, or the Unif	.S. Service Academy, Reserve or corned Services University of
ROUTINE USE:	To determine medical acceptabilit Information will be released to a social security number (SSN) is used	uthorized personnel involved in	e academies, ROTC or USUHS. In the selection process. The
DISCLOSURE:	Voluntary; however, failure to fu process and hamper your candidate		on will impede the selection
1. NAME OF APPLICANT (Las	st, First, Middle Initial)		2. SSN OF APPLICANT
MALIK, BONITA A			111-11-1111
		S TO EXAMINER	
of "innocent" or "func Defense Medical Exam	mitral valve prolapse and bicuspid a tional murmurs. We request that ination Review Board to make a pro	you complete this form which w	vill enable the Department of ant's cardiac status.
3. GRADE, AMPLITUDE OR			,
Grade I/VI Systo	lic Murmur	Apex	
5. TIMING DURING THE CA Mid Systolic	RDIAC CYCLE (e.g., mid-systole)		
6. CHARACTER OF THE SOL Decresendo	UND (e.g., crescendo-decrescendo)		
7. RADIATION OR TRANSM None	ISSION OF THE SOUND		
8. OTHER SOUNDS (e.g., click)		
Mid Systolic Cli			
9. RESULT OF ECHOCARDIC	OGRAM (Please attach results - NOT TRACINGS.)		
Mitral Valve Pro DOPPLER: No evi	lapse, minimal dence of mitral regurgitation	on	
10. FINAL IMPRESSION AN	D OTHER COMMENTS		
	by P.E. and by echo.		
11. EXAMINING PHYSICIAN		TURE	c. DATE SIGNED
Lowe, John E	SSC, PIEST, MADDIE INICIAN	W. EV	7 May 87
DD Form 2374, MAY 85	5		

	HEART MUF	ATION REVIEW BOARD (DODMERB	,	
	Privac	y Act Statement		
UTHORITY:	Title 10, USC 133, 3012, 5031,	8012 and Executive Order 9397.		
RINCIPAL PURPOSE:	Officer Training Corps (ROTC Health Sciences (USUHS).	art of the application process to a (;) Scholarship Programs, or the Uni	Hormed Services	
OUTINE USE:	Information will be released social security number (SSN) is	ability for one or more of the servic to authorized personnel involved s used for positive identification.	in the selection	J104033. 1114
DISCLOSURE:	process and hamper your candidacy.			
NAME OF APPLICANT (Last, First, Middle Initial) 2. SSN OF APPLICANT				
	INSTRUC	TIONS TO EXAMINER		
		spid aortic valve are being found in that you complete this form which a proper determination of the appli	cant's cardiac sta	
. GRADE, AMPLITUDE OR	INTENSITY (Use the I-VI Scale)	4. LOCATION (Where is the sound heard be	est?)	
3. GRADE, AMPLITUDE ON INTENSIVE (SAME AND				
	ARDIAC CYCLE (e.g., mid-systole)			
6. CHARACTER OF THE SC	DUND (e.g., crescendo-decrescendo)			
6. CHARACTER OF THE SO 7. RADIATION OR TRANSI 8. OTHER SOUNDS (e.g., cla	MISSION OF THE SOUND			
7. RADIATION OR TRANSI	MISSION OF THE SOUND			
7. RADIATION OR TRANSI	MISSION OF THE SOUND	35.)		
7. RADIATION OR TRANSI 8. OTHER SOUNDS (e.g., clr	MISSION OF THE SOUND	33.)		
7. RADIATION OR TRANSI	MISSION OF THE SOUND	55.)		
7. RADIATION OR TRANSI	MISSION OF THE SOUND	33)		
7. RADIATION OR TRANSI	MISSION OF THE SOUND ch) HOGRAM (Please attach results - NOT TRACING	55.)		
7. RADIATION OR TRANSI 8. OTHER SOUNDS (e.g., cli	MISSION OF THE SOUND ch) HOGRAM (Please attach results - NOT TRACING	3)		
7. RADIATION OR TRANSF 8. OTHER SOUNDS (e.g., chi 9. RESULT OF ECHOCARD	MISSION OF THE SOUND ch) HOGRAM (Please attach results - NOT TRACING	5.)		
7. RADIATION OR TRANSF 8. OTHER SOUNDS (e.g., chi 9. RESULT OF ECHOCARD	MISSION OF THE SOUND ch) HOGRAM (Please attach results - NOT TRACING	33)		
7. RADIATION OR TRANSI 8. OTHER SOUNDS (e.g., ch 9. RESULT OF ECHOCARD 10. FINAL IMPRESSION A	MISSION OF THE SOUND Ck) HOGRAM (Please attach results - NOT TRACING	55.)		
7. RADIATION OR TRANSF 8. OTHER SOUNDS (e.g., chi 9. RESULT OF ECHOCARD	MISSION OF THE SOUND Ch) HOGRAM (Please attach results - NOT TRACING	b SIGNATURE		C DATE SIGNED

DD FORM 2375, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) PULMONARY FUNCTION STUDIES

		DOD MED PUI	MEDICAL EXAMINATION PULMONARY FUI	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) PULMONARY FUNCTION STUDIES	ODMERB) ES		
			Privacy Act Statement	Statement			
AUTHORITY:	Title 10, USC 1	33, 3012, 5031, 8012	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397	. 9397.			
PRINCIPAL PURPOSE:	To update a medical fil Scholarship Programs, or	medical file as pari ograms, or the Unifo	t of the application ormed Services Univer	e as part of the application process to a U.S. Service Aca the Uniformed Services University of Health Sciences (USUHS)	a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Programs, or the Uniformed Services University of Health Sciences (USUHS).	erve Officer Trainir	ng Corps (ROTC)
ROUTINE USE:	To determine authorized pe	medical acceptabili rsonnel involved in t	ity for one or more he selection process.	of the service acade The social security n	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.	IS Information will repositive identificat	i be released to tion.
<u>DISCLOSURE</u> :	Voluntary; ho	wever, failure to fur	nish the requested in	formation will imped	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.	is and hamper your o	candidacy
1. NAME OF APPLICANT (Last, First, Middle Initial)	(, First, Middle Initial)			2. SSN OF APPLICANT		3. DATE OF EXAMINATION	NOI
DOE, JOHN E				000-00-0001		7 May 87	
4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE. THEOPHYLLINE TEST	ROVIDE THE RESI	JLTS OF A BLOOD AMIN	IOPHYLLINE/	5. SPECIFIC REFERENCE	5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL	FOR NORMAL	
Theophylline level:	el: Ong/ml	_		Normal therap	Normal therapeutic range 10-20 ng/ml	Ong/ml	
6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES	CONSIST OF 8 TO	10 MINUTES OF RUNNI N TEST IMMEDIATELY U	OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED DIATELY UPON CESSATION OF	' BE ACCOMPLISHED	NOTE: Administer th	Administer the bronchodilator 4 minutes after exercise and	es after exercise and
THE EXERCISE. STATE DURATION OF EXERCISE -	JRATION OF EXER	CISE	•	10 mins	perform the f	perform the function test one minute thereafter.	hereafter
			TEST	TEST RESULTS			
		a. BEFORE	a. BEFORE EXERCISE	b. AFTER	AFTER EXERCISE	C. AFTER BRONCHODILATOR	CHODILATOR
		NORMAL (1)	7. PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
7. TOTAL VITAL CAPACITY		05.4	%68	4.30	85%	4.55	206
8. FEV - 1.0		3.97	%56	3.73	89%	80.4	97%
9. MEFR 25 - 75 %		4.42	87%	3.99	78%	5.01	286
10. WAS WHEEZING PRESENT	1	YES	ON	11. IS THE PATIENT TA	11. IS THE PATIENT TAKING ANY MEDICATIONS? (XORE)	(X one)	
4 BEFORE EXERCISE			X	After the supplemental to	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
b AFTER EXERCISE			×	ON A			
12. EXAMINER							
. IVEC OR PRINTED NAME (LOSI, FIRST, MIGGIE INITIAL) WALLY, Edward P	t, fust, Middle initial)			b Signature	0000		
Chief, Pulmonary Clinic, WBAMC,	/ Clinic, WB	AMC, EP, TX			7	.1	
DD Form 2375, MAY 85							

		DOD MEDIC	CAL EXAMINATION	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)	DMERB)		
		PUL	MONARY FUN	PULMONARY FUNCTION STUDIES	S		
			Privacy Act Statement	Statement			-
AUTHORITY:	Title 10, USC 133, 3012,	33, 3012, 5031, 8012 3	5031, 8012 and Executive Order 9397	9397. process to a U.S. Se	rvice Academy, Res	erve Officer Training	Corps (ROTC)
PRINCIPAL PURPOSE:	Scholarship Pro	medical life as pair ograms, or the Unifor	med Services Univers	Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS)	s (USUHS).		
ROUTINE USE:	To determine medical	medical acceptabilit	by for one or more in selection process.	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.	nies, ROTC or USUH mber (SSN) is used fo	 Information Will repositive identification 	De released to
DISCLOSURE:	Voluntary; ho	wever, failure to furn	iish the requested inf	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.	the selection proces	s and hamper your ca	andidacy.
1. NAME OF APPLICANT (Last, first, Middle Initial)	st, First, Middle Initial)			2. SSN OF APPLICANT		3. DATE OF EXAMINATION	
4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A THEOPHYLLINE TEST	PROVIDE THE RESU	JLTS OF A BLOOD AMINOPHYLLINE/	DPHYLLINE/	5. SPECIFIC REFERENCE	5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL	FOR NORMAL	
6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 M ON A TREADMILL. PERFORM THE FUNCTION TEST OF EXERCISE.	CONSIST OF 8 TO ORM THE FUNCTION	VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF PARTICLE CLATE DIJECTION OF EXERCISE.	NG. THIS EXERCISE MAY	BE ACCOMPLISHED	NOTE: Administer th perform the f	Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter	s after exercise and pereafter
			TEST R	TEST RESULTS			
		SUPERING SACES	EXERCISE	b. AFTER	b. AFTER EXERCISE	C. AFTER BRONCHODILATOR	CHODILATOR
		NORMAL	£	NORMAL	% PREDICTED	NORMAL (1)	→ PREDICTED (2)
		ε	(3)	C			
7. TOTAL VITAL CAPACITY	> -						
B. FEV-1.0							
9. MEFR 25 - 75 %					·		
			(11. IS THE PATIENT TA	11. IS THE PATIENT TAKING ANY MEDICATIONS? (xone)	(x one)	
10. WAS WHEEZING PRESENT	TX	YES	ON.	a. YES (Specify medications and usage)	tions and usage)		
& BEFORE EXERCISE							
b AFTER EXERCISE				Q A			
C AFTER BRONCHODILATOR							
12. EXAMINER	see First Middle Initial)			b. SIGNATURE			
S TYPED OR PRINTED NAME LE							
, pitt							
DD Form 2375, MAY 85	2						

DD FORM 2377, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST				
	Privacy Act Stateme	<u>ent</u>	"	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Execu	tive Order	9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the app Officer Training Corps (ROTC) Scholarship I Health Sciences (USUHS).	lication po Programs,	rocess to a US Service or the Uniformed Serv	Academy, Reserve vices University of
To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.				
1. NAME OF APPLICANT (Last, First, Middle Initial) 2. SOCIAL SECURITY NUMBER OF APPLICANT				
FRELIX, ROSS L.	000 00 0000			
3. "I certify that Applicant (Examinee) (X One) XX a. CAN b. CAN NOT distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. (Do not readminister standard color vision test.)				
4. EXAMINER				
a. TITLE OF EXAMINER Color Vision Sp	b. SIGNATURE OF EXAMINER Company	ch	on lace	c. DATE SIGNED 7 May 87
DD Form 2377, MAY 85				

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST			
	Privacy Act Statement		
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Orde	er 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the application of Officer Training Corps (ROTC) Scholarship Programs Health Sciences (USUHS).	process to a US Service Academy, Reserve , or the Uniformed Services University of	
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.		
Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.			
1. NAME OF APPLICANT (Last, First, Middle Initial) 2. SOCIAL SECURITY NUMBER OF APPLICANT			
3. "I certify that Applicant (Examinee) (X One) a. CAN b. CAN NOT distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. (Do not readminister standard color vision test.)			
4. EXAMMER			
a. TITLE OF EXAMINER DD Form 2377, MAY 85	b. SIGNATURE OF EXAMINER	c. DATE SIGNED	

DD FORM 2378, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEADACHES

s ⁻	DOD MEDICAL EXAMINAT TATEMENT OF HISTOR	TION REVIEW BOARD (DODMERB) RY REGARDING HEADAC	HES	
	Privacy	Act Statement		
AUTHORITY:	Title 10, USC 133, 3012, 5031, 80	012 and Executive Order 9397.		
PRINCIPAL PURPOSE:	Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).			
ROUTINE USE:	Information will be released to social security number (SSN) is u		he selection process. The	
DISCLOSURE:	Voluntary; however, failure to process and hamper your candid	o furnish the requested information dacy.	will impede the selection	
	INS	TRUCTIONS		
Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use reverse side of this form.				
1. HOW OFTEN DO YOUR HEADACHES OCCUR? (e.g., monthly, quarterly, every six months, etc.)				
Once a month.				
2. WHEN HEADACHES OCCU	JR, WHAT IS THEIR FREQUENCY? (eg.o	ince a day, twice, three times, etc.)		
once a day.				
3. HOW LONG DO THE HEA	DACHES USUALLY LAST? (e.g., 1 hour, 2 ho	ours, 6 hours, etc.)		
2 hours			·	
4. HAVE YOU EVER TAKEN Tylenol	ANY MEDICATIONS FOR YOUR HEADA	CHES? IF SO, PLEASE EXPLAIN IN DETAIL (e	g., what medication, usual dose, etc.)	
191011				
<u></u>				
5. DO HEADACHES INTERFE	RE WITH NORMAL ACTIVITIES?			
NO				
l e	ENT INFORMATION CONCERNING THIS	PROBLEM		
N/A				
7. HAS A PHYSICIAN DIAGR	OSED YOUR HEADACHES? IF SO, WH	IAT WERE THE FINDINGS?		
Tension headac	hes		•	
O ADDIVANT				
8. APPLICANT a. SIGNATURE		b SOCIAL SECURITY NUMBER	c. DATE SIGNED	
1 Kan Ka	anold)	001-00-1001	5 May 87	

DD Form 2378, MAY 85

S			REGARDING HEA		HES
		Privacy Act	tatement		
AUTHORITY:	Title 10, USC 13	3, 3012, 5031, 8 012 an	d Executive Order 9397		
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification. Voluntary; however, failure to furnish the requested information will impede the selection				
DISCLOSURE:	Voluntary; how process and had	wever, failure to furn mper your candidacy.	sh the requested info	rmation	will impede the selection
		INSTRUC	TONS		
Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use reverse side of this form.					
1. HOW OFTEN DO YOUR HEADACHES OCCUR? (e.g., monthly, quarterly, every six months, etc.)					
2. WHEN HEADACHES OCCU	JR, WHAT IS THEIR	FREQUENCY? (e.g. once a day.	Nunce, three times, etc.)		
3. HOW LONG DO THE HEA	DACHES USUALLY	LAST? (e.g., 1 hour, 2 hours, 6 hou	rs, etc)	-	
4. HAVE YOU EVER TAKEN	ANY MEDICATIONS	FOR YOUR HEADACHES?	IF SO PLEASE EXPLAIN IN	DETAH (c.	
a. HAVE TOO EVEN TAREN			T JO, TENJE ENTENIE IN	DETAIL (E)	y, what medicalium, usual dose, etc.)
S. DO HEADACHES INTERFE	RE WITH MORMAL	ACTIVITIES?			
3. 50 112.00.00					
6. LIST ANY OTHER PERTINI	INT MECONA TION	CONCERNING THE BROSES	·		
& USI ANY OTHER PERIM		CONCERDING THIS PROBLE			
THE A PHONE THE PARK THE CHARLES	OSED VOUS HEAD	CUECO IS CO. MINIST MIST	IF THE EINDHUGE		
7. HAS A PHYSICIAN DIAGN		CHES? F SO, WHAT WE	E THE FINDINGS?		AND
	·····				
8. APPLICANT					
a SIGNATURE			6 SOCIAL SECURITY NUMBER		C DATE SIGNED

DD Form 2378, MAY 85

DD FORM 2379, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEAD INJURY

	DOD MEDICAL EXAMINATION REVIEW BOARD STATEMENT OF HISTORY REGARDING	D (DODMERB) HEAD INJURY	,
	Privacy Act Statement		
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Orde	er 9397.	Ì
PRINCIPAL PURPOSE:	To update a medical file as part of the application Officer Training Corps (ROTC) Scholarship Programs Health Sciences (USUHS).	s, or the Uniformed	Services University of
ROUTINE USES:	To determine medical acceptability for one or more Information will be released to authorized personn social security number (SSN) is used for positive identi	nel involved in the s fication.	selection process. The
DISCLOSURE:	Voluntary; however, failure to furnish the requested process and hamper your candidacy.	ed information will	impede the selection
1. NAME OF APPLICANT	last, First, Middle Initial)	2. SSN Of	CANT
BENNETT, TERRY	3.	001-1.	11
	INSTRUCTIONS		
Please answer the fol needed, use the rever 3. HOW DID THE HEAD I Playing footbal	lowing questions regarding head injury. Be very spec se side of this form. NJURY OCCUR?	cific in your answers	. If additional space is
4. HOW OLD WERE YOU 15 years old	WHEN IT HAPPENED?		
5. WERE YOU UNCONSCI yes, 2 minutes	DUS? HOW LONG?		
6. DID YOU HAVE A SKU No	ILL FRACTURE?		
7. DID YOU HAVE ANY ETC.? HOW LONG DID	SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, THE SYMPTOM(S) LAST?	VOMITING, AMNESIA,	DOUBLE VISION, DIZZINESS,
Dizziness for	5 minutes.		
8. WERE ANY ADDITION PREUMOENCEPHALOG	NAL PROCEDURES ACCOMPLISHED SUCH AS ELECTROEI RAM, ETC.?	NCEPHALOGRAM, BRA	IN SCAN, BURR HÖLES,
Skull x-rays w	hich were normal.		
9. SIGNATURE OF APPL	CANT	10. DATE SH 7 May	
DD Form 2379, MAY	85		

	DOD MEDICAL EXAMINATION REV STATEMENT OF HISTORY REG		
	Privacy Act Stat	ement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Ex	ecutive Order 9397	
PRINCIPAL PURPOSE:	To update a medical file as part of the Officer Training Corps (ROTC) Scholarsh Health Sciences (USUHS).	application process ip Programs, or th	to a US Service Academy, Reserve e Uniformed Services University of
ROUTINE USES:	To determine medical acceptability for of Information will be released to authori social security number (SSN) is used for po	zed personnel invo	lived in the selection process. The
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.		
1. NAME OF APPLICANT O	.ast, First, Middle Initia()		2. SSN OF APPLICANT
	INSTRUCTIO	NS .	
Please answer the foil needed, use the revers	lowing questions regarding head injury.	Be very specific in	your answers. If additional space is
3. HOW DID THE HEAD II			
		·	
4. HOW OLD WERE YOU	WHEN IT HAPPENED?		
····			
5. WERE YOU UNCONSCIO	OUS? HOW LONG?		
			· · · · · · · · · · · · · · · · · · ·
·			
6. DID YOU HAVE A SKU	ILL FRACTURE?		
7. DID YOU HAVE ANY	SYMPTOMS AFTER THE INJURY, FOR EXAMPLE:	HEADACHES, VOMITIE	IG, AMNESIA, DOUBLE VISION, DIZZINESS,
ETC.7 HOW LONG DID	THE SYMPTOM(S) LAST?		
	IAL PROCEDURES ACCOMPLISHED SUCH A	ELECTROENCEDHA!	OGRAM, BRAIN SCAN, BURR HOLES,
8. WERE ANY ADDITION PNEUMOENCEPHALOG	RAM, ETC.?	- ELECTROPHICE THAL	OGRAM, SIGNIV SCAN, SCAN
9. SIGNATURE OF APPLI	CANT		10. DATE SIGNED

DD Form 2379, MAY 85

DD FORM 2380, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING

ST	DOD MEDICAL EXAMINATION I ATEMENT OF HISTORY RE		
	Privacy Act S	tatement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 a	and Executive Order 9	397 .
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS). To determine medical acceptability for one or more of the service academies, ROTC or USUHS.		
ROUTINE USES:	To determine medical acceptability Information will be released to aut social security number (SSN) is used	horized personnel in	volved in the selection process. The
DISCLOSURE:	Voluntary; however, failure to furr process and hamper your candidacy.	nish the requested in	formation will impede the selection
1. NAME OF APPLICANT (La	t, First, Middle Initial)		2. SSN OF APPLICANT
TIPTOE, JO	HNNY T.		100-01-1000
	INSTRUCT	nons	
Please answer the follo needed, use the reverse	wing questions regarding sleepwalkin side of this form.	g. Be very specific in	your answers. If additional space is
3. HOW FREQUENT ARE EP Twice a mont	SODES OF SLEEPWALKING? h		
4. WHEN DID YOU LAST SL April 1987, 17	EEPWALK (month and year) (age)?		
April 1907, 17	years ord	 	
	RTINENT INFORMATION RELATED TO YOUR SI		
I get up in the	middle of the night and walk	into the living	room. I wake up in
the living room	and don't remember how I got	there.	
· · · · · · · · · · · · · · · · · · ·			
6. SIGNATURE OF APPLICA	NT		7. DATE SIGNED
Johnnes	T Tixtol		1 May 87
DD Form 2380, MAY 85	, , ,		

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING			
	Privacy Act Statemen	<u>it</u>	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Exec		
PRINCIPAL PURPOSE:	Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).		
ROUTINE USES:	Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.		
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.		
1. NAME OF APPLICANT (Last	, First, Middle Initiel)		2. SSN OF APPLICANT
Please answer the follow needed, use the reverse 3. HOW FREQUENT ARE EPIS		ery specific in	your answers. If additional space is
3. 1100 TREQUENT AND 1			
4. WHEN DID YOU LAST SLE	EEPWALK (month and year) (age)?		
		 	
5. PROVIDE ANY OTHER PER	RTINENT INFORMATION RELATED TO YOUR SLEEPWAL	KING.	
		9	
6. SIGNATURE OF APPLICAT	NT		7. DATE SIGNED

DD Form 2380, MAY 85

DD Form 2381, MAY 85

DD FORM 2381, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING MOTION SICKNESS

STA	DOD MEDICAL EXAMINATION REVIEW BOARD (DO ATEMENT OF HISTORY REGARDING MOTION		
	Privacy Act Statement		
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 939	7.	
PRINCIPAL PURPOSE:	Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).		
ROUTINE USES:	To determine medical acceptability for one or more of the Information will be released to authorized personnel invisocial security number (SSN) is used for positive identification	olved in the selection process. The	
DISCLOSURE:	Voluntary; however, failure to furnish the requested inf process and hamper your candidacy.	ormation will impede the selection	
1. NAME OF APPLICANT	.ast, First, Middle Initial)	2. SSN OF At ANT	
MELLS, FRED D.		100-00-7010	
	INSTRUCTIONS		
needed, use the revers	owing questions regarding motion sickness. Be very specific is side of this form.	n your answers. If additional space is	
	VESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNIVAL RIDES, ETC.).		
Sea sickness			
4. WHAT AGE DID IT FIRS 14 years old	T HAPPEN?		
5. HOW SEVERE AND FRE	QUENT ARE EPISODES? day while deep sea fishing. This happened on	ly once	
I was sick all	day while deep sea listing. This happened on	ly once.	
6. PROVIDE ANY OTHER I	PERTINENT INFORMATION RELATED TO YOUR MOTION SICKNESS.		
I have gone fi	shing since and not gotten sea sick.		
7. SIGNATURE OF APPLIC	ANT (O)	8. DATE SIGNED 2 Apr 87	
	/	1	

STA	DOD MEDICAL EXAMINATION REVIEW ATEMENT OF HISTORY REGARD	N BOARD (DODMERB) ING MOTION SICKNESS				
	Privacy Act Stateme					
UTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Execu	itive Order 9397.				
RINCIPAL PURPOSE:	Officer Training Corps (ROTC) Scholarship (Health Sciences (USUHS).	olication process to a US Service Academy, Reserve Programs, or the Uniformed Services University of				
COUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.					
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selectic process and hamper your candidacy.					
. NAME OF APPLICANT	(Last, First, Middle Initial)	2. SSN OF APPLICANT				
	INSTRUCTIONS					
Please answer the fol needed, use the rever	lowing questions regarding motion sickness. E	Be very specific in your answers. If additional space is				
. TYPE OF MOTION SICK	NESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNI	VAL RIDES, ETC.).				
. WHAT AGE DID IT FIR	ST HAPPEN?					
	Mark and the state of the state	<u> </u>				
5. HOW SEVERE AND FI	REQUENT ARE EPISODES?					
5. HOW SEVERE AND FI						
5. HOW SEVERE AND FI						
5. HOW SEVERE AND F						
5. HOW SEVERE AND FI						
		ON SICKNESS.				
	REQUENT ARE EPISODES?	ON SICKNESS.				
	REQUENT ARE EPISODES?	ON SICKNESS.				
	REQUENT ARE EPISODES?	ON SICKNESS.				
	REQUENT ARE EPISODES?	ON SICKNESS.				
	REQUENT ARE EPISODES?	ON SICKNESS.				
	REQUENT ARE EPISODES?	ON SICKNESS.				
	REQUENT ARE EPISODES?					
	REQUENT ARE EPISODES? R PERTINENT INFORMATION RELATED TO YOUR MOTIC	DN SICKNESS. 8. DATE SIGNED				

DD FORM 2382, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES

STATEMENT OF	DOD MEDICAL EXAMINATION REVIEW HISTORY REGARDING HAY FEVER,	W BOARD (DODMERB) SINUSITIS, ASTHMA AND/OR ALLERGIES					
	Privacy Act State						
AUTHORITY:	Title 10, US Code 133, 3012, 5031, 8012 an						
PRINCIPAL PURPOSE:							
THIRTH ALTON OSE.	Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).						
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.						
DISCLOSURE:	Voluntary; however, failure to furnish t process and hamper your candidacy.	he requested information will impede the selection					
1. NAME OF APPLICANT (LA	st, First, Middle Initial)	2. SSN OF APPLICANT					
MARPEL, MARY M.		000-01-0000					
	INSTRUCTION	<u>s</u>					
Please answer the foll answers. If additional		itis, asthma and/or allergies. Be very specific in your					
3. NUMBER AND APPROXI	MATE DATES OF ATTACKS OR EPISODES.						
5 episodes: 23	Tay 85, 14 July 85, 1 October 85,	30 January 86 and 14 Apr 87.					
4. SIGNS, SYMPTOMS AND	DURATION OF ATTACKS.						
Wheezing, shortn							
5. TYPE AND AMOUNT OF	MEDICATION USED AND LENGTH OF TREATMENT. 3 times a day for 30 days.						
Theodur 300 mgs,	3 chiles a day 101 30 days.						
	N OF HYPOSENSITIZATION (DESENSITIZATION) (IF A	NY) EMPLOYED, GIVING INCLUSIVE DATES.					
N/A							
7. HAS MAINTENANCE DO	SE BEEN ATTAINED?						
Proventil as nee	ded prior to exercises. OF ASTHMA AND DATE LAST ASTHMA MEDICATIO	N WAS USED.					
16 years old	Ur ASIRMA AND DAIE CASI ASIRMA MEDICARIO						
9. IS THERE ANY HISTORY	OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EX	PLAIN.					
	where the same						
10. SIGNATURE OF APPLIC	ant M Marie	14 -May 87					
DD Form 2382, NAY 8	7 Previous edition						

STATEMENT OF	DOD MEDICAL EXAMINATION REVIEW HISTORY REGARDING HAY FEVER,	EW BOARD (DOD SINUSITIS, AS	MERB) STHMA AND/OR ALLERGIES				
	Privacy Act State	ment					
AUTHORITY:	Title 10, US Code 133, 3012, 5031, 8012 and		nber 1943 (SSN).				
PRINCIPAL PURPOSE:	The contract of the contract o						
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.						
<u>DISCLOSURE</u> :	Voluntary; however, failure to furnish t process and hamper your candidacy.	tary; however, failure to furnish the requested information will impede the selection is and hamper your candidacy.					
1. NAME OF APPLICANT (L.	sst, First, Middle Initial)		2. SSN OF APPLICANT				
	INSTRUCTION						
Please answer the follows	owing questions regarding hay fever, sinus space is needed, use the reverse side of this	 sitis, asthma and/o	or allergies. Be very specific in your				
	MATE DATES OF ATTACKS OR EPISODES.						
4. SIGNS, SYMPTOMS AND	DURATION OF ATTACKS.						
	OF TOTAL OF THE PARTY.						
5. TYPE AND AMOUNT OF	MEDICATION USED AND LENGTH OF TREATMENT.						
6. TYPE OF AND DURATIO	IN OF HYPOSENSITIZATION (DESENSITIZATION) (IF A	NY) EMPLOYED, GIV	ING INCLUSIVE DATES.				
7. HAS MAINTENANCE DO	SE BEEN ATTAINED?						
	OF ASTHMA AND DATE LAST ASTHMA MEDICATION						
9. IS THERE ANY HISTORY	OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXI	PLAIN.					
10.SIGNATURE OF APPLIC	ANT		11.DATE SIGNED				

DD Form 2382, MAY 87

Previous edition may be used

DD Form 2383, MAY 85

DD FORM 2383, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATION

	STATEMENT OF USE REGARDING MEDICATI						
	Privacy Act Statement						
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.						
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).						
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.						
DISCLOSURE:	Voluntary; however, failure to furnish the requested information process and hamper your candidacy.	on will impede the selection					
1. NAME OF APPLICANT (La	st, First, Middle Initial)	2. SSN OF APPLICANT					
WHITE, REBECCA		010-00-1010					
	INSTRUCTIONS	-					
	following questions regarding use of medication. Be very specific i	n your answers. If additional					
space is needed, use re-							
3. TYPE OF MEDICATION Actifed		· · · · · · · · · · · · · · · · · · ·					
4. REASON FOR USAGE Allergies							
!							
	TAKEN THE AMERICATIONS						
5. HOW LONG HAVE YOU 13 days	TAKEN THIS MEDICATION?						
_	OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL? (List type and reas	on for usage)					
No							
		A DATE CICNED					
7. SIGNATURE OF APPLICA	1 White	8. DATE SIGNED 5. May 87					

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERS STATEMENT OF USE REGARDING MEDICAT) 10N				
	Privacy Act Statement					
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.					
PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).						
ROUTINE USE:	To determine medical acceptability for one or more of the servic Information will be released to authorized personnel involved Social Security number (SSN) is used for positive identification.	in the selection process. The				
DISCLOSURE:	Voluntary; however, failure to furnish the requested informat process and hamper your candidacy.	ion will impede the selection				
1. NAME OF APPLICANT (LA	st, First, Middle Initial)	2. SSN OF APPLICANT				
	NICTOLICE COLIC					
	INSTRUCTIONS following questions regarding use of medication. Be very specific	in your answers. If additional				
Please answer the space is needed, use re	tollowing questions regarding use of medication. De very specific exerse side.	THE YOUR ANSWERS. THE GOOD TO THE				
3. TYPE OF MEDICATION						
4. REASON FOR USAGE						
5. HOW LONG HAVE YOU	TAKEN THIS MEDICATION?					
6. HAVE YOU TAKEN ANY	OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL? (List type and re	ason for usage)				
~~~						
<u> </u>						
		B. DATE SIGNED				
7. SIGNATURE OF APPLIC	ANT	V. DATE STATES				

DD Form 2383, MAY 85

## DD FORM 2489, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST

## DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST

#### Privacy Act Statement

AUTHORITY:

Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE:

To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services

University of Health Sciences (USUHS).

**ROUTINE USES:** 

To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection

process. The social security number (SSN) is used for positive identification.

**DISCLOSURE:** 

Voluntary; however, failure to furnish the requested information will impede the

selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)

2. SSN OF APPLICANT

MOORE, JOHN X.

000-00-0100

#### INSTRUCTIONS TO EXAMINERS

Please read reverse side of this form before administering this test.

Indicate by letters in each given block which colors were observed by the examinee for each run of the test (e.g., R/W, G/R, etc.).

	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
1st RUN	G/R	W/W	G/W	G/R	R/G	W/R	w/w	G/W	R/R	3
2nd RUN	G/R	W/G	G/W	G/G	R/G	W/R	w/w	R/W	R/R	Ø
3rd RUN	G/R	W/R	G/W	G/G	R/G	W/R	W/W	R/W	R/R	ø

3. REMARKS (Continue on reverse if necessary)

4. SIGNATURE OF	EXAMINER	5. DATE SIGNED
$\mathcal{A}$	( )000 000 - 1150 =	16 Jun 87

### FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

#### PREPARATION FOR TESTING

- 1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.
- 2. Only one person should be tested at a time. (Others shall not be allowed to watch.)
- 3. Station examinee eight feet from lantern.
- 4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, <u>must be removed</u> prior to testing.

#### ADMINISTRATION AND SCORING

- 1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors red, green, and white and top first."
- 2. Turn knob at top of lantern to change lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.
- 3. Expose the lights in random order starting with a RG or GR combination (Numbers 1 or 5), continuing until each of the nine combinations has been exposed.
- 4. If no errors are made on this first run of nine pairs of lights, examinee is passed.

- 5. If any errors are made on this first run, give <u>two</u> more complete runs.
- 6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.
- 7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.
- 8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors red, green, and white."
- 9. If an examinee takes a long time to respond, you should say, "As soon as you see the lights, call them."

REMARKS (	ontinued)
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				Priva	cy Act Sta	tement					
<u>AUTHORITY</u> : Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).											
PRINCIPAL	. PURPOS	Resen	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).								
ROUTINE	USES:	USUH	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.								
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4. SIGNATURE	OF EXAMIN	IER				_		S. DATE S	HGNED		

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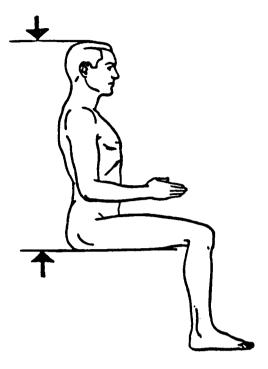
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REMARKS (Continued)			

#### ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS

This attachment gives guidelines on the additional medical information needed along with the physical examination of applicants to a US service academy (Air Force, Military, Naval, Coast Guard, Merchant Marine), Four-Year ROTC Scholarship, or the USUHS.

- a. Reading Aloud Test (RAT). Administer the RAT to all applicants. The test must be given as follows:
- (1) Have the examinee stand erect, face the examiner across the room, and read aloud the statement in 2 below, as if he or she were confronting a class of students.
- (2) If he or she pauses, even momentarily on any phrase or word, the examiner immediately and sharply says, "What's that?" and makes the examinee start over again with the first sentence of the text. The true stammerer usually will halt again at the same word or phonetic combination, and will often show serious stammering.
  - "You wish to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet, he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter, when the ooze of snow or ice is present, he slowly takes a short walk each day. We have often urged him to walk more and smoke less, but he always answers. "Banana oil!" Grandfather likes to be modern in his language."
- b. Sitting Height. To measure sitting height, have the examinee sit on a hard surface, hips flexed at 90 degrees (°), lower legs dangling free, and torso erect, with head facing directly forward. Measure from the top of the head to the top of the hard surface the examinee is seated upon. Measure sitting height to the nearest quarter of an inch. (See diagram.)



- c. Near Point of Accommodation. Have the examinee wear his or her usual corrective lenses. The object of the test is to determine the nearest point where the examinee can read print that is 1 millimeter (mm) (.62 Snellen-Metric), or J-2) high. Hold the test card so near the eye that the examinee cannot read it, then slowly move it away until the examinee can read the print correctly. Record the results for each eye in diopters. If an ophthalmologist or optometrist is doing the test, with the manifest refraction findings in place, use monocular push-up amplitude of accommodation and record the results for each eye in diopters.
- d. Near Point of Convergence (NPC). The object of the test is determining the point on a ruler where eye convergence is the greatest. Place the ruler's zero mark about 15 mm from the corneal surface. Start the movable object at the far end of the ruler, and move it slowly toward the nose. The point of convergence is the point on the ruler where eye convergence is the greatest, but without breaking fusion. Record the results in millimeters.
- e. Red Lens Test. The examinee should be 30 inches from a tangent screen or a central fixation point. The fixation point should be on a plain wall, 48 inches from the floor, with intersecting lines of 45°, 90°, 135°, and 180°,

running at least 20 inches from the point of fixation. These lines may be marked at 4-inch intervals, and a cord 30 inches long fastened at the fixation point to measure the testing distance. the examinee's eye should be on an exact line, perpendicular to the fixation point so that the head and eyes are not tilted in any direction. Seat the examinee on an adjustable stool and steady his or her head by placing the chin on a chin rest, so that the visual axis will not change during the test. Put a red lens in front of one of the examinee's eyes. Then move a point of light outward in the six cardinal directions from the center of the screen; right, left, up and to the right, up and to the left, down and to the right, and down and to the left. Instruct the examinee to follow the light with his or her eyes, without moving his or her head, and to tell you if there is either a change in the color of the light (suppression) or a doubling of the light (diplopia). Demonstrate a change in the color of the light at the beginning of the test, showning that it may be either red, white, or pink, by using an occluder. Move the light into one of the upper diagonal fields until the brow cuts off the view from one, to verify that the examinee understands. The examinee should report a change in color. Place a five diopter prism, base up or base down, before one eye to produce diplopia, which the examinee should report. This will avoid the danger of routine negative responses. If you wish, alternate this prism with a plano lens of the same size to confuse the examinee. Note and record the point on the screen if the examinee has diplopia or suppression when no prism is being used.